

# Retirement Migration, The Other Story: The Lived Experiences of Vulnerable, Older British Migrants in Spain

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# Abstract

Over the last few decades, Spain has become a popular retirement destination for British nationals. Most retire abroad when they are healthy; however, happy and fulfilling retired lives in Spain can abruptly change when a person's resources (bodily, economic and social) for independent living diminish. Therefore, the onset of old age can bring about severe vulnerability and the need for additional support becomes vital. This study looks at the lived experiences of vulnerable, older members of the British community as they age in Spain, focusing on those who are in serious need of help and support. It examines the nature of difficulties faced, as well as the networks and services that support these individuals.

This thesis is a product of collaboration between academics and Age Concern in the UK and Spain. Through a survey of enquiries to Age Concern España and narrative interviews with vulnerable, older British households in Spain, the research examined the challenges and crises faced as a result of ageing, which tend to be centred on a decline in health, the need for care, bereavement and insufficient financial resources. These are common difficulties faced by many older people; however, this thesis looks at these challenges within the context of living in Spain where language, culture and legal barriers restrict access to support. Vulnerability largely arose due to the limited availability of and access to health/care services, as well as financial support in Spain.

However, the ability to cope with vulnerability or a crisis also depended on the availability of social networks for support. The Grid and Group theoretical framework was utilised to examine the ways in which vulnerable, older British people in Spain respond to challenges or crises by drawing upon their social networks for support. This is the first time the framework has been used to look at vulnerability and support in old age. The findings of this study have been used to promote the needs of vulnerable older British people in Spain through a series of policy recommendations, as well as recommendations for good practice utilised by Age Concern España and other voluntary organisations in Spain.

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# Chapter 1 - Introduction

This thesis is part of an ESRC CASE studentship in collaboration with Age Concern, which examines the lived experiences of older British people Spain. It concentrates on those who are vulnerable or in serious need of additional help and support, and examines their changing needs as a result of ageing in Spain. It explores the nature of support available to these individuals and how this support is utilised during times of crisis or when long-term care is required. This includes an examination of informal social networks, support from statutory/voluntary organisations and the impact of British, Spanish and European Union (EU) policy.

This introductory chapter explains the background to the study, including the development of retirement migration to Spain over the past few decades, the nature of retirement migration to Spain, the number of older British people in Spain and the increasing vulnerability of older British people in Spain. It then introduces the research aims and finally provides an overview of the thesis.

## 1.1 Background

The past few decades have seen a considerable increase in the number of older British people retiring abroad. Changes to work and retirement patterns, as well as greater wealth and longevity in later life, have led to longer periods of retirement, which can provide an opportunity to live abroad (King *et al.*, 2000). Warnes (1992) has argued that for many individuals older age is no longer a time restricted by ill health and physical or mental incapacities, and instead has been converted to a 'third age' of life during which new social and recreational activities are pursued. The third age follows economic activity and provides an opportunity to develop a fulfilling lifestyle separate from the world of work (Bond and Corner, 2004).



As a result, the lifestyles of older people today are more likely to be characterised by individualisation, mobility, choice and flexibility (Beck and Beck-Gernsheim, 2002), which can involve taking frequent holidays abroad or other types of international mobility, including international retirement migration (IRM) (Beck, 2000). Therefore, people in the third age with sufficient resources are still able to make conscious choices about where they want to live and the lifestyles they wish to live by, with place of residence emerging as a central feature of this development (Phillipson, 2007). Whilst the recent credit crunch has left many older people with a lower disposable income and some retiring later (Masters, 2009), economic instability in the UK may also be encouraging others to move abroad (PrudentMinds, 2008).

Research to date has tended to look at the reasons why people retire abroad and at their lifestyles during the third age of life when they are happy and healthy. However, little research has been undertaken on what happens to retired migrants when they reach old age and enter the ‘fourth age’ of dependence and decline<sup>1</sup> (Laslett, 1991). During this final stage of life, frailty, disability and social exclusion are common, primarily as a result of disease and physical and cognitive impairments (Bond and Corner, 2004). The fourth age is a time when vulnerability becomes more prominent as older people may be subjected to increased risks and are less able to cope with any challenges that arise, including a decline in health, frailty, reduced financial resources and loneliness/social isolation<sup>2</sup>. This thesis therefore tells the ‘other story’ by examining the lived experiences of older British people living in Spain who are in the fourth age of final decline and dependence and are considered to be especially vulnerable. As a result of an increased vulnerability to ill health, a lack of care, poverty or social isolation, such people may be in need of additional support and help.

However, living in Spain can bring unique challenges to vulnerable older British people due to the nature of support and care available to them. This includes informal support from family and friends who are separated by distance, as well as formal care from

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<sup>1</sup> The actual age at which someone reaches the fourth age can vary according to individual and environmental factors, however tends to begin from the mid-70s.

<sup>2</sup> The third/fourth age of life and vulnerability are discussed in more detail in Section 2.1.

statutory services, many of which are different in Spain compared with the UK. Vulnerable older British people in Spain have not yet been the focus of research and therefore this thesis begins to fill this gap by examining their lived experiences as they age in Spain, looking at the challenges they face and the nature of support that they receive.

### ***1.1.2 Retirement Migration to Spain***

Whilst migration to rural and coastal areas within the UK remains a common choice for retirement (Lowe and Speakman, 2006), growing numbers are choosing to retire abroad (Sriskandarajah and Drew, 2006). Non-EU countries remain a popular choice, with the preferred destination for UK state pensioners being Australia (Sriskandarajah and Drew, 2006). There is a growing body of evidence of the popularity of North-South retirement migration within Europe (e.g. King *et al.*, 2000; Ackers and Dwyer, 2002; O'Reilly, 2007). For many decades Spain has been a popular retirement destination for older EU nationals, including Swedish (Gustafson, 2001) and British nationals (O'Reilly, 2000a). Mass international tourism began in Spain upon the establishment of democracy following the death of the Spanish Dictator, General Franco in 1975. This led to the removal of disincentives for immigrants and British people began to buy second or permanent homes in Spain (O'Reilly, 2000a). Spain is now the second most common retirement destination for older British people (Sriskandarajah and Drew, 2006).

The exact number of British people living in Spain remains unclear due to under-registration and fluid migration patterns, especially among older migrants. It is estimated that there are nearly a million British people living in Spain (Sriskandarajah and Drew, 2006) and various institutional bodies have attempted to estimate the number of older British people living there. There is however, a vast discrepancy between official figures of registration by the Spanish Padron (Municipal Register) and the Department for Work and Pensions (DWP), in comparison with significantly higher estimates of the *de facto* number by the Institute for Public Policy Research (IPPR) (see *Fig. 1.1*). This can be

attributed somewhat to IPPR figures showing those over the age of 45 and official figures only those over pension age (65/60), however these figures do highlight the vast numbers of older British people who are not registered as living in Spain. Non-registration may be due to people spending only part of the year abroad (see *Fig. 1.3*) or alternatively people choosing to retain rights in the UK, such as to healthcare (Coldron and Ackers, 2007).

***Fig. 1.1 - Summary of Statistics on Older British People in Spain  
(based on latest figures from 2006)***

*IPPR* – 600,000 British people over 45 years living in Spain for all/part of the year.  
*Spanish Padron* – 75,054 British people over state pension age (SPA) in Spain.  
*DWP* – 75,200 British people receiving their state pension in Spain.

(Sources: Srisikandarajah and Drew (IPPR), 2006:19; Instituto Nacional de Estadística (Spanish Padron), 2007; DWP, 2006a)

Most older British people in Spain reside in coastal locations (King *et al.*, 2000). Most British people (of all ages) live in the province of Alicante (Costa Blanca), followed by Malaga (Costa del Sol), the Canary Islands and the Balearic Islands (Instituto Nacional de Estadística, 2007) (see *Fig. 1.2*). These figures however must be treated with caution as they only represent those who have officially registered and are only indicative of all British people in Spain rather than only older British people.

**Fig. 1.2 – Main Locations of British People in Spain (Approximate Numbers)**



(Source: Map from <http://www.holiday-villa-direct.com/images/map-of-spain.gif>;  
Statistics based on latest figures from Instituto Nacional de Estadística, 2007)

International retirement migration has been noted as a particularly fluid form of migration, which involves complex mobility patterns (Huber and O'Reilly 2004; Warnes *et al.*, 1999, 2004). Retired British people living in Spain form a nebulous population and are therefore often difficult to categorise. Many are undocumented as they do not register with the host country, as indicated by the differences between official and unofficial statistics presented in *Fig. 1.1*. A number of studies have attempted to devise typologies of international mobility based on movement characteristics and orientation towards home (e.g. O'Reilly, 2000a; King *et al.*, 2000). Based on a review of these studies, *Fig. 1.3* summarises three types of older British migrant in Spain.

**Fig. 1.3- Typology of Retired Migrants in Spain**

**Full/Permanent Residents:** these are migrants who have moved permanently, most of whom own property in Spain. They live in Spain and often have no intention of returning to their country of origin (O'Reilly, 2000a; King *et al.*, 2000).

**Returning Residents:** these are resident in Spain with regards to home, orientation and legal status but return to Britain each summer for between 2 and 5 months to escape the summer heat and crowds of tourists (O'Reilly, 2000a). Many own homes in both Spain and the UK and others stay with relatives or friends in the UK.

**Seasonal Migrants/Visitors:** these are resident in the UK with regards to home, orientation and legal status but return to Spain each winter for up to six months. They usually have property in the UK and abroad (O'Reilly, 2000a). Generally, these elderly 'swallows' move south in the winter to escape the northern cold and move back north in the height of summer to avoid the heat (Champion and King, 1993).

The above typology highlights the different types of retirement migration and the complexity and flexibility of international migration. This thesis is concerned with retirement migration; however, this typology shows that the concept has no static definition and that multiple forms exist. Older British people in Spain therefore include those who are resident in Spain and live there on a permanent basis, to those who move back and forth. In addition, individuals may move between categories over time as their migration patterns change, e.g. a seasonal migrant may move to Spain permanently. This can have implications on rights to healthcare and welfare support, which is especially important for those who are frail and vulnerable, and will be examined further in this thesis.

Different forms of retirement migration may mean that the nature of ties that binds retired migrants to the UK and Spain can vary substantially. Some maintain strong social networks in the UK, whilst for others links are weak or have dissipated (Huber and O'Reilly, 2004; Hardill *et al.*, 2005). The social networks of older British migrants can also be complex as they often transcend national boundaries e.g. networks in both Spain

and the UK. As a result, British migrants in Spain have been labelled ‘transmigrants’ (O’Reilly, 2007), whereby they belong to two or more countries at the same time and construct dual lives across national borders (Vertovec, 2005; O’Reilly, 2007). Social networks are especially important for the provision of support during old age and poor social networks have been shown to increase vulnerability (Grundy, 2006).

There appears to be an increasing number of vulnerable older British people living in Spain who are entering extreme old age and are in need of additional support (Hardill *et al.*, 2005). Most people retire abroad when they are healthy; however, happy and fulfilling retired lives in Spain can abruptly change with the onset of illness or when a person’s resources (bodily, economic and social) for independent living diminish (e.g. Dwyer, 2000, 2001; Hardill *et al.*, 2005; Age Concern, 2007). Therefore, the onset of old age can bring about severe vulnerability and can radically reduce quality of life, meaning that the need for additional support and care becomes vital. The availability of informal support can be limited by moving abroad, as relatives and friends may be separated by distance.

In addition to informal social support, the availability of health, care and welfare support services can become important during old age. There are, however, significant differences between the welfare regimes and social care systems of Spain and the UK (Esping Anderson, 1990). This is largely due to cultural differences, as in Spain there is an expectation that family will care for elderly relatives (Da Roit, 2007). Compared with the UK, there is a relatively low level of public and private personal social service provision for older people (Tortosa and Granell 2002). The provision of publicly-funded residential, day and domiciliary services is increasing, but demand often outstrips supply (Hardill *et al.*, 2005). As a result, the level of social care support and welfare benefits available to vulnerable older British people in Spain may be lower than they would be able to access in the UK. This is compounded by language barriers, as a significant number of older British people speak little or no Spanish (O’Reilly, 2000a; King *et al.*, 2000) hindering their integration with the local community, navigation of local

bureaucracy and perhaps access to services. As a result, some older British people are returning to the UK to access support (Age Concern, 2007; Hardill *et al.*, 2005).

Growing numbers of British people living in Spain are turning to British charities for help. Age Concern España is one such charity which supports older British people in Spain who are experiencing difficulties. Research by Hardill *et al.* (2005) found that the nature of enquiries for help and advice received by Age Concern España was changing, with requests for help with severe problems such as care and repatriation increasing indicating the increased vulnerability of this ageing population. Hardill *et al.*'s study found that Age Concern España receive around 12,000 enquiries a year, with many being requests for information about health-care, benefits, local services, and the 'Spanish system'. However, they also found that around one in eight notifies a serious need for additional income or support. Hardill *et al.* note that these are people who are in critical situations and have experienced a radical decline in quality of life due to a decline in health or lack of finance, both of which can be exacerbated by social isolation and communication difficulties. Whilst the authors recognise that these problems are also prevalent in the UK and not unique to older migrants, the nature of support available to British people in Spain can be different to those living in the UK, both in terms of support from family and friends, as well as formal support and entitlements.

This thesis takes forward the findings of this study and further examines the lived experiences of vulnerable, older British people in Spain who have accessed support from Age Concern España. As identified by Hardill *et al.* (2005), many Age Concern España service users are in 'critical situations' as a result of a decline in health or lack of finance. Therefore, rather than focusing on the reasons for moving and the experiences of older British people in Spain as many previous studies have, this thesis looks at the complexities of ageing in Spain by identifying a sub-set of those who are vulnerable and in need of additional help and support. It examines the type of vulnerability that they face, including the difficulties or crises that result in vulnerability, as well as the networks that support these individuals. It aims to identify which country/countries support is sought from and therefore looks at the extent to which older British people in Spain are

transnational. This is currently a largely under-researched area and as such, this thesis tells the “other story”; the stories of older British people in Spain who are in the ‘fourth age’ of decline and dependence, and who are in serious need of additional help and support. Against this background, the following aims have been identified.

## **1.2 Aims and Objectives**

The research has three main aims which are as follows;

1. To examine the lived experiences of vulnerable, older British people in Spain focusing on the difficulties and crises they face as a result of changing life circumstances with ageing.
2. To examine the kinds of support networks that vulnerable, older British migrants construct and access in the UK and Spain (e.g. family network, friendship network, voluntary sector) and the role that they play during times of crisis.
3. To examine the impact of UK, EU and Spanish policy on the rights of vulnerable, older British people living in Spain to access healthcare, social care and social security.

In order to meet these aims, the thesis addresses the following seven research questions;

1. What are the most significant difficulties or crises facing older British people living in Spain which contribute to them becoming vulnerable?
2. What formal and informal social and support networks do older British people in Spain construct and access, and what role do they play in response to difficulties or crises?
3. Where are the social networks of vulnerable, older people living in Spain located and to what extent are individuals transnational?



4. To what extent can and do vulnerable, older British people in Spain access healthcare, social care and welfare services in Spain and the UK (or elsewhere)?
5. Do older British people in Spain return to the UK when they encounter a crisis in Spain and what are the experiences of those who decide to return?
6. To what extent do British voluntary services in Spain, such as Age Concern España, support vulnerable, older British people living in Spain?
7. To what extent does UK, EU and Spanish policy recognise the needs of vulnerable, older British people living in Spain?

### **1.3 Outline of the Thesis**

This thesis is organised into eight chapters. Following this introductory chapter, the existing literature related to the current study is discussed. The literature review is split into two chapters. *Chapter Two* examines the social networks of vulnerable, older British people in Spain and how these networks are utilised in the provision of care and support during old age. It also discusses vulnerability in old age, including the main difficulties faced by older people. It also introduces the Grid and Group theoretical framework that is being taken forward in this study.

*Chapter Three* examines the rights and entitlements of older British people in Spain, especially in relation to health, care and financial support during old age. It therefore addresses the health care, social care and welfare services that are available to and accessed by these individuals in Spain. It also discusses the complexities of returning to the UK to access support.

*Chapter Four* introduces the research methodology and research design, beginning with some background on the collaborative work undertaken with Age Concern. The two research stages are discussed; a survey of enquiries to Age Concern España and in-depth interviews with vulnerable older British households in Spain.

Chapters Five, Six and Seven present the research findings and discussion of the data. These are organised into the three key areas; social, health and financial issues. *Chapter Five* presents the social networks of interview respondents and the nature of support available to and utilised by them. This chapter employs the Grid and Group theoretical framework to identify four distinct groups of older migrants in Spain based on their characteristics and social network type; the Isolates, Enclaves, Individualists and Hierarchy types.

*Chapter Six* presents issues around health and care including the main health difficulties facing participants. It also addresses the healthcare entitlements of older British people in Spain and the different ways in which they have accessed health and care services. *Chapter Seven* is the final data analysis chapter and presents the financial difficulties facing participants and the financial support available to older British people in Spain.

*Chapter Eight* is the final chapter of this thesis and presents the broad theoretical and practical issues arising from this research. The chapter focuses on the theoretical issues of vulnerability, quality of life, social networks and transnationalism. The chapter then concludes the thesis by outlining a series of policy and practice recommendations.

# **Chapter 2 – The Social and Support Networks of Vulnerable Older British People in Spain**

This is the first of two literature review chapters. It discusses vulnerability in old age, including the main difficulties faced by older people and the areas in which they may be vulnerable. Social support has been shown as essential in reducing vulnerability (Grundy, 2006; Schroder-Butterfill and Marianti, 2006), so this chapter reviews the literature on the social networks of older people, and more specifically the networks of older British people in Spain and ways in which they are utilised to provide care and support. After reviewing the social networks of older people generally, it looks more specifically at how social networks can be affected by retirement migration. It examines where the social networks of older British migrants are located, so the concept of transnationalism is introduced and discussed. Finally, an outline of the Grid and Group typology is provided, detailing how the theory is being utilised in this study to examine the social networks and coping strategies of vulnerable, older British people living in Spain.

## **2.1 Vulnerability and Quality of Life in Old Age**

Older people are a diverse and heterogeneous population and as such ‘old age’ can be a difficult concept to define. Official government documents tend to classify older people as being over the age of 50, including the Department of Health (DoH) (2007a; 2001) who identifies three distinct groups of older people based on their needs:

- those entering old age who have completed their paid employment or child rearing;
- those in a transitional phase between a healthy, active life and frailty within their late 60s and early 70s where crises may be more likely to arise; and
- those aged 75 and over who are frail and vulnerable as a result of ill health or declining mobility.

Therefore, the Department of Health categorises those over the age of 75 as being particularly vulnerable as a result of ill health, with the late 60's being a time when frailty and vulnerability may begin. Old age has also been categorised into the third and fourth age. Laslett (1991) identified four stages of the life course with the third age effectively beginning at the point of retirement (so the age at which someone enters the third age can vary from person to person). The third age is the stage of life where personal goals, distinct from the world of work, can be realised and as such is known as the age of personal achievement and fulfilment. Third agers tend to be the young old (mid-60s to mid-70s), as they are people in relatively good health and are socially engaged (Neugarten, 1974). The ability to live a happy and fulfilling third age is therefore dependent upon retaining good health following retirement and being financially secure. As a result, the third age has become synonymous with well-off ageing (Bond and Corner, 2004). Whilst current generations of older people may have a longer life expectancy and greater wealth than previous generations, the notion of a third age is somewhat biased towards middle class values.

The fourth age on the other hand has been associated with 'deep old age' and is not necessarily based on chronological age but on "frailty, disability and social exclusion on the basis of disease and physical and cognitive impairments" (Bond and Corner, 2004:14). The fourth age therefore begins at the final stage of the life course before death and is often a time of dependence and decline. It is characterised by physical and psychological decline and as such those in the fourth age tend to experience a lower well-being and quality of life compared with third agers. The age at which the fourth age begins has been debated and as the Department of Health typology above suggests, the

fourth age tends to include those over the age of 75; however, others have linked it with the oldest old or those over the age of 85 (Smith, 2001). In reality, the age at which someone reaches the fourth age varies from person to person as it is not possible to say that everyone over the age of 75 or 85 is frail and dependent, as some people maintain a good quality of life until they die. There may also be gender differences in the onset of the fourth age, as the life expectancy of women is higher than men, suggesting that men may reach the fourth age before women. Chronological age therefore does not itself dictate vulnerability because as Laslett (1991) indicates, medical uncertainties may prematurely bring about the onset of the fourth age. He has recognised that the fourth age is often dependent upon medical and biological uncertainties and as such may come upon people without them being aware of its arrival and so affects their sensibilities and judgement. Nonetheless, what is evident is that as people become old, they become more vulnerable, especially to ill health.

The above discussion therefore suggests that older people become increasingly vulnerable from their late sixties and in a state of final decline by their late seventies or early eighties. Whilst people may reach the fourth age at different times depending on biological and social factors, fourth agers are considered to be especially vulnerable as this is usually a time of final decline and dependence. Vulnerability is associated with a decline in quality of life and is most frequently linked to ill health or frailty (Higgs *et al.*, 2003). 'Frailty' is a term that indicates a sense of physical weakness, as well as a higher risk of mortality or loss of autonomy (Grenier, 2007) and can lead to increased vulnerability (Brocklehurst and Laurenson, 2008). However, health is not the only indicator of vulnerability, as definitions of vulnerability must go beyond aspects of frailty and embrace wider social factors (Brocklehurst and Laurenson, 2008). This may include vulnerability to poverty, inadequate care or social isolation in old age. Older people can therefore encounter multiple vulnerabilities.

Definitions of vulnerability are often quite vague, as for example the New Oxford Dictionary of English definition of being vulnerable is being exposed to the possibility of being attacked or harmed, either physically or emotionally (Schroder and Gefenas, 2009).

This definition would suggest that most people are vulnerable, as the risk of harm (however minor) is always present in everyday life, for example people put themselves at risk of being harmed when crossing the road. Instead vulnerability is about being more likely to encounter threats or challenges and lacking the resources to successfully cope with those challenges. Schroder and Gefenas (2009:117) have therefore devised an alternative and more precise definition which is; “to be vulnerable means to face a significant probability of incurring an identifiable harm, while substantially lacking ability and/or means to protect oneself”. This takes into account the resources people possess which they can utilise to prevent vulnerability, as for example having a private pension significantly reduces the risk of economic vulnerability in old age.

This is supported by Schroder-Butterfill and Marianti (2006) who state that “a person’s vulnerability is the result of the inter-related risks of being exposed to a particular threat, encountering that threat, and lacking the resources to respond in such a way as to avert serious harm”. They argue that it is therefore the outcome of complex interactions of being exposed to a threat, that threat actually arising and then lacking the defenses or resources to overcome that threat. Vulnerability is therefore often shaped or exacerbated by inequalities, disempowerment or access to social protection. Schroder-Butterfill and Marianti (2006) stress the importance not only of formal social protection but informal social support from family and community networks, especially for older people who are faced with vulnerabilities surrounding intimate care, emotional support or social participation. This highlights the importance of social networks in reducing old age vulnerability and is examined further in this chapter.

Another notable author who has addressed vulnerability is Grundy (2006:107) who defines vulnerable older people as “those whose reserve capacity fall below the threshold needed to cope successfully with the challenges that they face”. She argues that individual or environmental resources can be deployed to help overcome vulnerability and these primarily include reserves of mental and physical health; family relationships and social networks; and wealth/other material resources. It is not only these available resources that are important but a person’s ability to draw upon them. She particularly

stresses the importance of social support in reducing old age vulnerability, especially family ties.

Vulnerability can occur at any age, yet older people may be more vulnerable as they face more risks than younger groups, including a decline in health, loss of income or the loss of a spouse, and they also have reduced resources available to them to overcome these risks (Schroder-Butterfill and Marianti, 2006). Vulnerability in old age can be reduced by limiting the number of challenges faced and by providing adequate physical, financial and social support (Grundy, 2006). Laslett (1991) also states that the onset of the fourth age can be put off for as long as possible through appropriate behaviour during the third age, for example by not smoking or by having a private pension. This therefore highlights the importance of forward planning as a way in which vulnerability can be reduced. By ensuring financial and social support systems are in place, risks are reduced and a crisis may be averted.

The main areas of risk for older people are to poor health/frailty, insufficient care, poverty or social isolation (Grundy, 2006; Schroder-Butterfill and Marianti, 2006). As a result, physical/care, financial and social resources have been shown as important in reducing vulnerability to a poor quality of life in old age (e.g. Gabriel and Bowling, 2004; Grundy, 2006). Quality of life refers to people's emotional, social and physical well-being and their ability to function in the ordinary tasks of living (Donald, 2008). Gabriel and Bowling's (2004) quality of life survey of over 65's in the UK found the following factors to have the greatest impact on quality of life: good social relationships with family, friends and neighbours; good home and neighbourhood social capital (including good and safe facilities such as transport); positive psychological wellbeing and outlook; social activities/hobbies; good health; being financially secure; and independence. The ability to live independently is therefore associated with a good quality of life in old age (Gabriel and Bowling, 2004), whilst dependency is a factor linked with the fourth age indicating a poor quality of life and vulnerability (Brocklehurst and Laurenson, 2008). Therefore, quality of life, as with vulnerability, cannot be defined through physical health alone, but must take account of wider financial and social factors. Therefore, the main

vulnerabilities facing older people are poor health/frailty, inadequate care, insufficient financial resources and isolation/poor social support. Furthermore, older British people in Spain may be subjected to unique vulnerabilities as a result of living abroad. The health, economic and social challenges that may arise during old age are now briefly examined in more detail.

First, a decline in health (or increased frailty) is especially common during old age, often resulting in physical dependence on others (Schaie and Willis, 1991). This is indicative of the onset of the fourth age with final decline and dependence being strongly linked to a significant decline in physical and/or psychological health (Bond and Corner, 2004). Grundy (2006) argues that health is of overwhelming importance in understanding vulnerability in older people. She found that the most vulnerable groups with regards to health are the very old (over 85 years), particularly very old women, those with the lowest incomes and a background in less skilled occupations and those with low social support. Those from low socio-economic groups and those with less wealth on average encounter more illnesses and die earlier than their wealthier counterparts (Nazroo, 2008). This indicates the inter-related nature of health, financial resources and social support during old age.

Health problems can significantly reduce a person's quality of life, as can the poor health of others, especially a spouse (Gabriel and Bowling, 2004). Whilst the chance of getting physical diseases (such as cancer and heart disease), as well as mental illnesses (such as Alzheimer's or dementia) increases dramatically in old age, what is important is how these disabilities affect one's ability to function. When a health problem results in reduced mobility or an inability to look after oneself, the result can be physical and emotional dependence on other people as well as on health and social care services, including institutionalised care. Sufficient care in old age can therefore be especially important. However, moving abroad can bring specific health and care challenges, due to differences in health and social care provision and this is examined in more detail in Chapter Three.



Second, the quality of life of older people is markedly affected by their financial resources and poor financial security can increase vulnerability. Material wealth and income can decline in old age and Help the Aged (2008) found that nearly a quarter of state pensioners in the UK live in poverty. Although the real income of pensioners has increased dramatically over the past 20 years or so, older people have limited opportunities to undertake paid work following retirement, so their incomes are often fixed and dependent on their tangible assets such as savings and property and any past contributions to the economy (Grundy, 2006). As people age there is also a greater reliance on state benefits, particularly for those over the age of 75 (DWP, 2009). Social security benefits (including the old age pension) make up over half of UK pensioners income, whilst occupational and private pensions make up around a quarter, and the remaining incomes come from earnings and investment (or other) income (Office for National Statistics (ONS), 2009). In addition, a third of UK pensioners receive at least one income related benefit, such as Pension Credit, Housing Benefit or Council Tax Benefit and a quarter are in receipt of disability benefits (DWP, 2009). The average annual income from state pensions and related benefits for a UK pensioner is around £6,800 (ONS, 2009).

Financial challenges can reduce quality of life in old age and the EU Age and Attitudes Survey found that 44 percent of older people in the EU cited financial worry the main problem facing their age group (Walker, 1993 cited in Grundy, 2006). Financial worries include having enough money to pay bills and knowing that sufficient money will be available should an unexpected event arise (Gabriel and Bowling, 2004). Older British people in Spain are often in a financially privileged position when they move (King *et al.*, 2000; Ackers and Dwyer, 2002); however there are indications that less wealthy British people are also moving to Southern Europe (King *et al.*, 2000). For these people, moving abroad can bring specific financial challenges, which includes the impact of exchange rate fluctuations and the availability of benefits. Furthermore, an unexpected financial crisis can bring increased vulnerability. These issues are examined further in Chapter Three.

Finally, social resources have been shown as essential to successful ageing and in reducing old age vulnerability (Grundy, 2006). Wilhelmson *et al.* (2005) found social relationships to have the greatest impact on quality of life and Victor *et al.* (2004) suggest that in advanced old age, social factors are more important than biological or genetic ones. Gabriel and Bowling's (2004) above mentioned survey of older people found good social resources to be the most important determinant of a good quality of life, especially regular face-to-face contact with family and friends. They also found that bad relationships or the loss of family members or friends can reduce quality of life. Maintaining mobility, being socially connected, confident and independent in later life is linked with overall well-being and successful ageing (National Coalition for Active Ageing, 2005). Good social support can also reduce the risk of admission to institutional care (Bowling, 1991).

However, older people may become less active as they age thus reducing their ability to remain socially connected thereby making them more vulnerable. As people grow old, they tend to choose activities that are the least demanding which are often contained within the local environment (van der Meer, 2006). Droogleeve Fortuijn *et al.* (2006) looked at the activity patterns of older adults and found the presence of three types of activities: home based, which are family orientated activities such as housekeeping and hobbies at home; individualistic activities outside of the home, such as paid work, sports, cultural activities and entertainment; and finally participation in the local community, such as volunteering. She found that activities outside of the home that are most demanding in terms of physical and mental abilities as well as financial resources, cease to feature in the earliest stages of late adulthood. As a person ages, activities become more confined to the home until the only activities undertaken are personal activities such as sitting or contemplation. Therefore, the daily lives of older people become more focused on the home and less focused on social activities. A decline in social participation and therefore social support, could lead to increased vulnerability in old age.

Small social networks and confinement to the home in old age can result in increased vulnerability to isolation and loneliness. Research suggests that three different types of

isolation may exist: social isolation, which is caused by a lack of social integration and embeddedness and may be resolved by acquiring new contacts (van Baarsen *et al.*, 2001); emotional isolation, which refers to an absence of a reliable attachment figure, such as a partner so tends to be higher during widowhood (van Baarsen *et al.*, 2001) and physical isolation, which occurs as a result of physical inactivity, a lack of transport and confinement to the home (Droogleever Fortuijn *et al.*, 2006). Isolation has been linked to loneliness, which refers to a general lack of social contacts, intimacy, or support from social relationships and researchers have interpreted loneliness as a discrepancy between actual and desired interpersonal relationships (Dykstra and De Jong-Gierveld, 1994, cited in van Baarsen *et al.*, 2001). Loneliness and a lack of social contacts can significantly impact upon vulnerability and a poor quality of life in old age.

This thesis looks at what contributes to vulnerability among older British people in Spain. This section has discussed when ‘old age’ begins, and has shown how the onset of poor health, financial difficulties, and insufficient social support can lead to extreme vulnerability and a low quality of life. As a result, the impact of these three factors on ageing in Spain form the focus of this thesis. Health and financial resources will be returned to in Chapter Three, so this chapter now focuses on older people’s social resources which have been shown as the most contributing factor to vulnerability and a poor quality of life in old age (Gabriel and Bowling, 2004). Research shows that it is older people with small or non-existent family networks who are most vulnerable, especially to a lack of care, a low quality of life and a bad death (Schroder-Butterfill and Marianti, 2006; Grundy, 2006; Van Eeuwijk, 2006). Social networks are therefore essential in the provision of care and support during old age. The chapter now moves on to examine the literature on the social networks of older people and more specifically the social networks of older British people in Spain. The extent to which networks can be utilised for care and support is discussed.

## 2.2 Social Networks and Support

Research has highlighted the links between social networks and ideas about social exclusion and inclusion (Phillipson *et al.*, 2004). Social networks are a resource that offers access to information, places and social groups, and have been viewed as ‘structures of opportunity’ which may facilitate access to different kinds of resources thereby reducing vulnerability. Good social networks can have a positive effect on the health and well-being of older adults, whilst inadequate social networks have been linked with an increase in morbidity and mortality, possibly due to increased social isolation and loneliness (Lubben and Gironde, 2004).

Social networks have the potential to provide care and support, in the form of support networks. Although the terms social network and social support are sometimes used interchangeably, Bowling (1991) differentiates between the two, with ‘social network’ describing the set of people with whom one maintains contact and ‘social support’ being the interactive process through which assistance is obtained from one’s network. It is therefore not the social networks themselves that reduce vulnerability, but the ability to gain social support from them. This thesis examines the social networks of vulnerable older British people in Spain, but more specifically the extent to which networks are utilised for support and therefore used to cope with vulnerability or crises.

Social support can be mobilised in a number of different ways. House and Kahn (1985) identified three different types of social support: emotional (sense of belonging, affection), instrumental (tangible/material assistance) and informational (knowledge transfer or advice from others). These could be provided from either informal personal relationships with friends, family and neighbours or more formal social contacts including statutory, private and voluntary sectors. The type of social support obtained by older vulnerable British people in Spain is examined in this thesis, especially the type of people who provide support and where they are located e.g. the UK or Spain.

### ***2.2.1 Social Networks and Social Capital***

As mentioned above, social networks themselves do not reduce vulnerability. They can however be mobilised to provide social capital, which is understood in terms of the social resources and connections that an individual has at their disposal. Whilst the concepts of ‘social network’ and ‘social capital’ are often used synonymously, in fact social networks are only social capital when they are mobilised to pursue social advantage or overcome disadvantage (Anthias, 2007), such as when providing social support. Social capital can also be used to provide links to wider social networks opening up access to a more extensive range of information, material resources and social support, including care (Crow, 2004). Low social capital has also been linked to higher levels of vulnerability. Van Eeuwijk (2006) found that older people who lack social capital and whose social networks are characterised by little trust, reciprocation and co-operation, are more vulnerable than those with high levels of social capital and social solidarity. This is largely because they are excluded from networks that provide care and support in old age.

Social capital has become a widely used concept by academics and government bodies, however “...there are many possible approaches to defining it much to the exasperation of anyone trying to research it” (Office for National Statistics, 2001:5). One well known theorist within the social capital paradigm is Putnam, who defines it as “...connections among individuals – social networks and the norms of reciprocity and trustworthiness that arise from them” (2000:19). The concept is also associated with Bourdieu (1986, 1984) who identified three different types of capital that make up class positions in society: social, economic and cultural capital. He linked social capital to the membership of social networks and the way in which they are utilised;

The volume of the social capital possessed by a given agent...depends on the size of the network of connections he can effectively mobilize (Bourdieu, 1986: 249).

It is therefore not just membership of social networks or other social structures that is important but the ability to secure benefits from them; both material and symbolic. For

Bourdieu, social capital is also linked with economic and cultural capital. Economic capital refers to the economic or financial resources available to people, that improves their capacities in society. Economic capital gives access to most goods and services and is recognised by Bourdieu as the most important resource, as it is from economic capital that cultural and social capital may be derived (Bourdieu, 1986). Cultural capital on the other hand, is any form of knowledge, skill, or advantage one has which gives them a higher status in society, including high expectations and values (Bourdieu, 1986). It includes long-standing dispositions and habits acquired in the socialisation process, the accumulation of valued cultural objects, and formal educational qualifications and training. It can also include language ability, and for migrants particularly, the ability to speak the language of the host country. Those rich in cultural and economic capital are more likely to accumulate social capital. Bourdieu's (1984) central argument is that there is an uneven distribution of capital between social groups creating an inequality of access to certain resources.

Bourdieu therefore views social capital in terms of inequality, specifically from the point of view of individuals engaged in the pursuit of their own interests (Siisiainan, 2000). On the other hand, other theorists including Putnam (1993, 2000) and Coleman (1998) locate themselves instead within the more Durkheimian tradition of the construction of community and solidarity (Anthias, 2007). They link social capital with collective values and societal integration, whilst Bourdieu looks at the individual. Putnam looks not only at the benefits to individuals as Bourdieu does, but also of the benefits to nations, cities and neighbourhoods.

Putnam (2000) distinguished between different types of social capital; bonding (exclusive) and bridging (inclusive). He refers to bonding social capital as the relations between homogenous groups, such as family and close friends. This tends to reinforce exclusive identities and homogenous groups, and may therefore serve to exclude. Furthermore, strong ties found in bonding social capital can limit contact with wider groups of people and thus avenues of advancement (Patulny and Svendsen, 2007). Svendsen (2006) highlights the outcomes of excessive bonding to be widespread distrust,

prejudices, a lack of co-operation, group isolation and social poverty. Patulny and Svendsen (2007) found that this can happen when migrants are not properly integrated into Western societies and 'parallel societies' emerge, where negative bonding social capital is most dominant. This may be evident in the British enclaves as found in coastal parts of Spain, where British migrants tend not to integrate and are segregated from the host community (Huber and O'Reilly, 2004; O'Reilly, 2000a). It is likely that such people have limited or no access to support from the Spanish community, which may make them more vulnerable.

On the other hand, bridging social capital is "...outward looking and encompasses people across diverse social cleavages" (Putnam, 2000:22) and is important for links to external assets and for information diffusion. This type of social capital can be derived from club membership, neighbourhood networks and voluntary activity. Whilst such activities have been found among older British people living in coastal parts of Spain, they are often confined to within the British community and therefore can still serve to exclude other nationalities (Betty and Cahill, 1999). However, membership of Spanish clubs and integration into the Spanish community would be a sign of bridging social capital and may be useful to reduce vulnerability.

Bridging social capital is linked to inclusion/openness and as such has been deemed as positive, whilst bonding social capital is linked to exclusivity/closedness and is therefore conceived more negatively (Portes and Landolt, 1996). Furthermore, Putnam (2000) suggests that bonding capital is good for "getting by" whilst bridging social capital is used for "getting ahead". However, Patulny and Svendsen (2007:44-5) recommend that "...a harmonious mix of bridging/bonding social capital seems to be the solution" and "...policy makers should aim to facilitate and support inter-group bridging as well as the positive type of in-group bonding, but be aware of and prevent harmful in-group bonding".

Woolcock (2001) also developed the concept of linking social capital, which is the capacity to obtain resources, ideas and information from formal institutions beyond the

community. It occurs in relationships across a wide social divide so is different from bridging and bonding capital as it is concerned with relationships between people with differing levels of power, for example between an individual and a social services department (ONS, 2003). It is therefore useful in generating support or help from formal social institutions.

### ***2.2.2 Social Networks in Old Age: Providing Care and Support***

Social capital and support are derived from a person's social network. Therefore, the type and size of one's social network is crucial, as well as the ability to utilise it for support. This section looks at the social networks of older people as well as the different roles people play, particularly in terms of the level of support they may offer.

Social networks can be made up of informal and formal social ties. Informal social networks are generally made up of relationships with family and friends. There has been some debate over the definitions of 'family' and 'friend', with family being defined as a given relationship (through marriage or blood) and a friend defined as a chosen relationship. There has however been a blurring of boundaries between given and chosen relationships due to "...a complex process of suffusion between familial and non-familial relationships" (Pahl and Spencer, 2004:215). For instance, close friends may be more important than blood ties for some people, so those who matter most are considered as 'family' rather than those given as family. Weeks *et al.* (2001:9) suggest that friends are sometimes becoming "families of choice" as people have "...the right to define significant relationships and decide who matters and counts as family". They suggest that as the proportion of marriages ending in divorce increases and people are moving geographically and perhaps socially from their families of origin, friends are drawn upon for support and security. Weeks *et al.* (2001) are largely referring to the growth in same-sex relationships, which are becoming a more recognised family construction, especially with new legislation on same-sex marriages in the UK. They emphasise the differing forms that the family can take in contemporary society. Alternative family forms could



however also include retired migrants who move away from their family and create new family-like networks in the host country.

Informal social networks can be essential in the provision of care and support during old age (Bowling, 1991). However, friends and family often play different roles. Friendships can be more important than family as a means of socialising and integrating, as well as in retaining independence, as Allan (1989:96-7) suggests:

Having friends...to interact with signifies social competence, and for elderly people especially, a continuing independence. In contrast, without other sources of social involvement, interaction with adult children may symbolise what is usually an unwelcome dependence and a lack of wider social valuation.

Phillipson *et al.*'s (2001) UK based research found that friends were the largest single group listed in respect of intimate ties among older people and that in many instances they have played a substantial role in the provision of emotional support. For older people who require care, or are caring for a spouse/partner, friends can provide advice and support. Friends can also be involved in practical ways, such as with shopping and collecting medicine.

Friends also have a major role to play in helping older people come to terms with the emotional and practical difficulties of widowhood (Allan, 1989). Although it may be expected that widowhood can limit people's involvement with their friends, Utz *et al.* (2002) found that whilst social participation tends to decrease before the death of a spouse, informal support increases following the loss. Allan (1989) also found that following the death of a spouse, there is a change in the nature of friendships rather than a reduction, whereby friendship circles will be less towards their existing still married friends but towards more widows. This therefore highlights the way that friendships can change over the life course according to individual circumstances and events.

Although retirement is a time for generating new friendships and reactivating old ones, as people reach extreme old age and age related illnesses develop, opportunities for generating and servicing friendship become limited again (Allan, 1989). In addition, friendship networks decrease as friends become infirm or die. Older adults who are relatively healthy tend to have more diversified support networks than those who are frail (Keating *et al.*, 2003) and subsequently robust networks might often be least available to those who need them most.

Family, on the other hand, are argued to provide greater stability and are particularly crucial in the provision of support and care in old age. Most older people are connected to family based networks, which are a source of emotional, instrumental and financial support (Phillipson *et al.*, 2001). Park and Roberts (2002) claim that family remains the first source of support when things go wrong. Family support, especially from a spouse or daughter, is often essential in forestalling institutionalisation by providing care during illness or disability. A spouse or partner is usually the most important as both a confidant and the key provider of sustained help and support. However, for those whose partner has died or is in need of care themselves, primary kin (children and siblings) are most significant in the lives of elderly people, though for the childless, a niece or nephew may be important (Allan, 1989). Siblings are also important and ties can become more marked during old age. The relationship between parents and their adult children can be characterised as one of positive concern (Adams 1967), where each side feels a commitment to the other and a moral obligation to provide one another with support when needed. Subsequently, when it comes to long-term care, family members, especially children, tend to play a far more significant role than friends (Allan, 1989). Although friendships do maintain elements of positive concern they are better suited to providing short term assistance or help in a crisis rather than long term support.

However, for older British people in Spain, immediate and ongoing support from family (other than a spouse) may not be available due to geographical separation. Retired migrants often leave behind their family when they move. Instead migrants may have to rely more heavily on friends for long term support; however as the above discussion

suggests, friends are less likely to be a sustained source of help, especially when the need for long-term care arises. As a result, the social networks of older British people in Spain may be complex and diverse, and ongoing support or long-term care from family may be difficult to obtain.

Other sources of support for older people, especially those who are frail or housebound, are neighbours and proximal friends. They may prove to be an especially important source of support during a crisis. Gabriel and Bowling (2004) found that neighbours can even be an important substitution for family living nearby. Local ties can provide social identity, informal assistance and contribute to the well-being of older people (Pilch, 2006). For older people with limited mobility or who do not have access to a car, neighbours can provide practical help in the form of transport, such as to the shops or doctors. The General Household Survey (Coulthard *et al.*, 2002) indicates high levels of contact between older people and their neighbours and Willmott (1986) found that for older people, neighbours are a good source of companionship, a way of keeping touch with the community, and are also useful in case of an emergency. Therefore, neighbours may be useful in helping older people cope with short-term crises but may not be a source of support if the need for long-term care arises.

Social networks in old age can therefore be diverse and can determine the amount of support available. Therefore, good social networks made up of family, friends and neighbours can significantly reduce vulnerability in old age. Research has identified different types of social and support network configurations in old age, including that of Wenger (1991, 1997) who identified five distinctive types of elderly social and support networks (presented in *Fig. 2.1*) based on older people living in Wales. Social network types were based on the availability and proximity of family members, the degree of involvement with the wider community of friends, neighbours, community and voluntary groups, and the personality of the elderly person. She argued that by identifying the network type within which an older person is situated, it is possible to predict the types of problems that they may encounter and therefore the nature of their support needs.

**Fig. 2.1 – Types of Elderly Social and Support Networks**

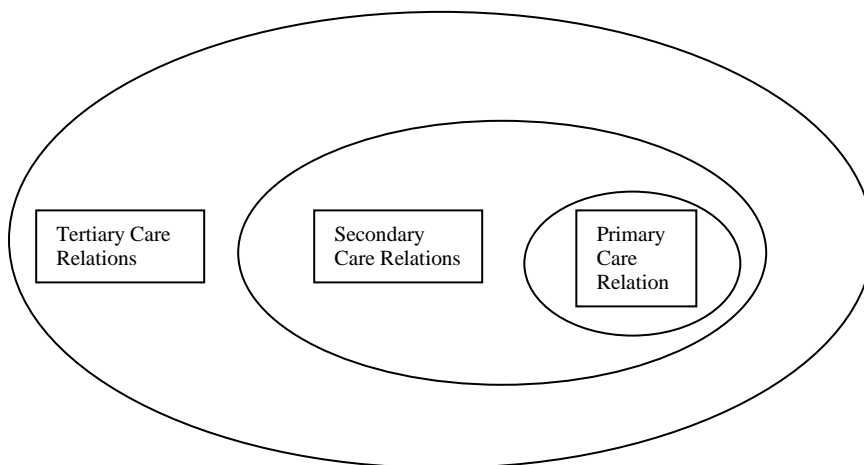
<i>The local integrated support network</i>	Locally based network of family, friends and neighbours. High level of community involvement. Fewest risks and few formal interventions.
<i>The local self-contained support network</i>	Made up of neighbours supplemented by kin living more than five miles away. Community participation is low. Household focused, privatised life style. Very vulnerable, as they may resist help or intervention unless it is crucial.
<i>The local family dependent support network</i>	Reliance on close family living locally. Few local contacts beyond the household. Tend to solve problems within the family without asking for professional help.
<i>The private restricted support network</i>	Limited informal support. Reliant on domiciliary services and professional help. The most vulnerable group.
<i>The wider community focused support network</i>	Absence of local family, but strong ties are maintained through telephone communication and visits. Extensive social networks are maintained with friends, neighbours and local organisations. Help in emergencies is forthcoming, but long term support can be difficult, so some professional help.

**Source: Adapted from Wenger (1991, 1997)**

Wenger's typology is however limited, especially for use in this thesis as it assumes that most social networks are locally based which may not be the case for many older British people living in Spain. On the other hand, she does indicate that the wider community focused network is most prevalent in areas of high retirement migration, so could be indicative of the older British community in Spain. This typology is useful as a heuristic device to look at levels of integration with the local community, whether there is a reliance on family or friends for support and if professional help is sought. It can also be used to explore the relationship between social network configuration, type of presenting problem, and the subsequent use of formal and informal help. It can therefore be useful as a device to link vulnerability in old age to social network support.

The type of support provided by different members of a person's social network can also be summarised in Lynch's (2007) 'concentric circles of care relations'. Her typology presents three main types of support or 'care work': primary, secondary and tertiary care relations (see *Fig. 2.2*). Primary care relations, also termed 'love labour', are primary and intimate relations where there is strong attachment, interdependence and intensity. This is emotionally engaged work with an intense sense of belonging and trust, and can be 24-hour care, as a result of high dependency needs. It may have little marginal gain for the carer and may even involve a net loss to them financially, socially or emotionally. This could be found in relationships between parents and children, or spouses/partners. However, such intimate support usually requires geographical proximity, so for older British people in Spain, primary care, especially from children, may be limited by distance. Therefore, a spouse may be the only person to provide such support. For those who are widowed, primary care relations may in fact be provided by a wider network of local friends or other family members.

***Fig 2.2 - Concentric Circles of Care Relations***



*Source: Lynch (2007:556)*

The second level of support is secondary care relations or 'general care work' involving outer circles of relatives, friends and neighbours, where there are lower order engagements in terms of time, responsibility, commitment and emotional engagement. Although there is some level of care responsibility, this is not with the same depth of

feeling or moral obligation as primary care relations. This type of care is likely to be context specific and subject to change, for example, a neighbour may no longer be a secondary care relation following a move to Spain. Secondary care work also includes engagement in voluntary and community associations which may improve quality of life and social capital (Gabriel and Bowling, 2004). Secondary care relations can also become primary relations and vice versa when friendships or intimate relationships change over time. The boundaries between primary and secondary care relations can therefore be blurred, especially among older British people in Spain whose family and close friends may not live locally.

Finally, tertiary care relations or ‘solidarity work’ “...involves largely unknown others for whom we have care responsibilities through statutory obligations at national and international levels, or for whom we care politically or economically through volunteering” (Lynch, 2007:556). They can usually be enacted without intimacy or personal engagement and is similar to ‘linking social capital’. This could also include formal care work such as that provided by hospitals where there is usually less emotional attachment. The nature of tertiary care can be dependent on local health and care services, and for older British people in Spain may be further compromised by language and cultural barriers. Lynch’s model is therefore useful when looking at different types of support and care relations, however is quite simplistic with different social network members having very defined roles. In reality, especially for older British people in Spain, the roles of different network members can be blurred, especially when the geographical proximity of close family and friends is taken into account.

The chapter now looks more specifically at the social and support networks of migrants, focusing on older British people in Spain. It highlights the often complex and diverse forms that social networks can take following retirement migration, and looks at whether older British people in Spain can be considered transmigrants whereby networks and identities are constructed across national boundaries.

### ***2.2.3 Social Networks, Social Capital and Migration: The Creation of Virtual and Transnational Communities***

Greater mobility, including retirement migration, over the past few decades has led to significant changes in social relations between individuals and societies. Some theorists have argued that as a result there has been a decline in social networks and social capital. One such theorist is Putnam (2000) who has argued that in the US, over the last third of the century people have become increasingly disconnected from one another and from communities, as both formal social connections (e.g. community involvement, volunteering) and informal social connections (ties with friends, family and neighbours) are in decline. People have fewer friends, community engagement is rarer and people trust each other less. This largely negative viewpoint has been echoed by sociologists, including Bauman (2000), who argues that people are increasingly disconnected and as such are neglecting their wider social responsibilities. He found that personal communities are fragile and short lived, and that a growth in individualism means that social ties are also becoming more superficial or “liquid”. He points to the negative effects of globalisation on our social relationships and identity, causing them to become more fragmented and transitory in nature.

This perspective can be mirrored through the ideas of Beck (2000) and Etzioni (1993) who also argue that there has been a growth in individualism, following the decline of the family and collapse of community, resulting in a less cohesive and stable society. Bellah *et al.* (1985) believe that the individual is the only form of reality and this undermines the essential forms of social obligation necessary for a morally cohesive life. Individualism is connected with the growth in privatised worlds which can propel individuals into shutting out others and the wider world from their emotional lives, resulting in shrinking communal ties and relations (Elliott and Lemert, 2006). Giddens (1998) has argued that this shift is largely due to globalisation which has led to people being disembedded from community life.

This largely negative view of globalisation and mobility indicates a decline in neighbourhood and community values, and an overall decline in the size and importance of social networks. This would suggest that international retirement migration may result in older people being disconnected from social and community networks and having smaller social networks. As a result, social support and informal care would be less widely available to them.

However, rather than a decline in social relations, we may in fact just be seeing the development of different types of transnational living in which communities are not tied to physical spaces. Globalisation, geographical mobility and technological advancement have led to a shift from place based communities, to communities based around relationships and social networks that are dispersed and maintained despite barriers of distance (O'Reilly, 2007; Phillipson, 2007). Social networks may therefore remain strong, but have simply been transformed with communities being virtual and transnational in nature, rather than being physically based. This can be seen through a growth in the use of modern information and communication technologies (ICTs) among older British people in Spain as a way to stay in touch with friends and family in the UK (or elsewhere) (O'Reilly, 2007). Therefore, rather than being in decline, social networks are taking new forms, with strong virtual social networks being created and maintained in place of physically based networks.

ICTs, which include the internet and email, provide opportunities for people to stay in touch with friends and family from abroad, as well as to make new friends (Selwyn *et al.*, 2003). There is some evidence that older British people in Spain are using ICTs, including emailing and text messaging (O'Reilly, 2007). Communication is also maintained through telephone calls and some are able to take advantage of cheap phone calls to the UK (Hardill *et al.*, 2004). Furthermore, the internet and satellite TV allow information and entertainment to be accessed entirely in English (Sriskandarajah and Drew, 2006), allowing migrants to maintain links with their home country. Baldassar (2007) looked at the different caring practices of Italian migrants in Australia and has critiqued the view that care-giving practices require geographic proximity. Her research



found that whilst certain personal care can only be provided through physical presence, phone calls and ICTs, including emails, are common ways in which migrants exchange emotional and practical care over a distance. Bowpitt and McCarthy (2008) also found that during times of illness, virtual support can be generated from professionals, friends and family. ICTs can also provide older people with quick and easy access to information, from health issues to local events (Social Exclusion Unit, 2005).

However, the extent to which older people use ICTs has been debated. Wilding (2006) found that family relationships can be maintained over distance through the use of modern ICTs such as email; however, the telephone and letter writing were still used more frequently, especially among older adults. Furthermore, some people are more able to access ICTs than others. Being very frail or disabled can restrict a person's ability to use ICTs, and as a result it is often older vulnerable migrants most in need of support who are unable to benefit from ICTs as a way in which to generate support from family living overseas. Wilding (2006) also found that during times of crisis or when care is needed, a telephone call or email is not sufficient and even intensified the sense of distance between elderly parents and their children.

As Wilding's above study indicated, the use of modern ICTs such as the internet may be quite low among older, vulnerable people. This is supported by Bowpitt and McCarthy (2008) who found that those over the age of 75 lack the skills necessary to use ICTs or have no interest in them. Many older adults face 'digital exclusion' as they are not part of the internet revolution with 78% of people over the age of 75 being digitally unengaged with low or moderate access to the internet (Hannon and Bradwell, n.d.). Older adults who are better educated, male, white, married, relatively well off and healthy are the least likely to be digitally excluded (Hannon and Bradwell, n.d.; Bowpitt and McCarthy, 2008). Those who are socially excluded are more likely to be digitally excluded (Bowpitt and McCarthy, 2008).

ICT use can bring a number of benefits including the development of social and support networks, practical and emotional care, as well as the alleviation of social isolation and

loneliness (Findlay, 2003). This is especially important for those living away from family and friends as many migrants are. However, there is currently very little research on the use of communication technology among British people abroad, especially among vulnerable, older British people in Spain with whom this thesis is concerned. This study therefore attempts to illuminate on the use of communication among older British people in Spain. It examines the extent to which the telephone and ICTs can maintain transnational relationships and can be utilised in the provision of support and care and thereby reduce vulnerability.

#### ***2.2.4 The Transnational Social Networks of Migrants***

The above discussion indicates that the social networks of migrants may go through significant changes following mobility. Some commentators have argued that existing social networks can break down following migration. Spencer and Pahl (2006) found that it is much easier to retain friendships if people remain in the same local area. In addition, Coleman and Putnam (cited in Evergeti and Zontini, 2006) see migration as directly linked to a decline in social capital as it diminishes social bonds and community ties. However, other scholars (including Evergeti and Zontini, 2006) argue that migration does not deplete social capital, but creates new forms of it. This could include virtual networks as discussed in the previous section. In addition, Victor *et al.* (2004) found that migrant networks are often very strong as members of a minority community may reach out and give support to new arrivals, so migrants are able to join an already established community, providing access to wider social networks and support. Wenger (1997) also found that moving can give people the opportunity to build new relationships, especially to make new friends. Migrants may in fact depend on networks and social capital in order to sustain their transnational life abroad (Vertovec, 2005).

Some British migrants in Spain, have been described as a diasporic community (O'Reilly, 2000a; Sriskandarajah and Drew, 2006), as they are a segment of people living outside of their homeland but continue to identify with their country of origin and other members of

the local community. Although the traditional description of a Diaspora is one of forced dispersal and oppression, more modern forms of social mobility associated with globalisation have increased diasporic networks across the world (Cohen, 1997). The term has now become one of self-identification among many varied groups who have migrated (Vertovec, 2005). It has been applied to groups who are “neither active agents of colonisation nor passive victims of persecution” (Cohen, 1997:ix), yet have maintained strong collective identities outside their homeland; “...a homeland which always has some claim on their loyalty and emotion” (Cohen, 1997:ix). Vertovec (2005:1) argues that;

...belonging to a Diaspora entails a consciousness of, or emotional attachment to, commonly claimed origins and cultural attributes associated with them. Such origins and attributes may emphasize ethno-linguistic, regional, religious, national, or other features. Concerns for homeland developments and the plight of co-Diaspora members in other parts of the world flow from this consciousness and emotional attachment.

O'Reilly (2000a) found that for most British migrants in Spain, Britain still remains part of who they are. Many “...retain a strong dependence on their home society, sometimes financially (e.g. pension) and sometimes emotionally (e.g. family ties)” and always have the “...secure knowledge that if all else fails, they can (and do) just go home” (2000a:159). Therefore, she argues that in such contexts the British can be conceptualised as a sort of Diaspora. Furthermore, Sriskandarajah and Drew (2006:viii) found that the British diasporic community is one of the largest in the world as “...when it comes to the absolute size and geographical spread of people around the world, it is likely that only the Indians and Chinese rival Britons living abroad”. This is because they generally have strong feelings of identity with and continued interest in the UK. However, there is not one overall British diasporic community sharing a collective identity but pockets of expatriates, of which older British migrants in Spain could be one.

More recently contemporary migrant communities and identities have been linked with the term ‘transnationalism’ (O’Reilly, 2007; Gustafson, 2001; Williams *et al.*, 1997; Bailey, 2001). A Diaspora is considered a transnational community when exchanges of resources or information, or visits take place either between members of the Diaspora or with people in the homeland. The concept of transnationalism has grown out of a recognition that migrants do not necessarily substitute old homes for new in a straightforward transfer, but often create active fields between the two (Hasmita, 2006). It is a multi-dimensional economic, cultural, demographic and political process which captures links between two or more settings in various nation states (Faist, 2008). Transmigrants are therefore “those whose lived experiences transcend the boundaries of nation-states” (Bailey, 2001:414) and “who develop and maintain multiple relationships – familial, economic, social, organizational, religious and political – that span those borders” (Basch *et al.*, 1994:7, cited in Bailey 2001:414). As a result, transnational lives embrace both the sending and receiving countries (Gustafson 2001) and strong social ties are usually maintained in both countries. Therefore, older British migrants in Spain may be transnational when their social networks are located in both Spain and the UK (and possibly elsewhere).

#### ***2.2.5 Are Older British Migrants in Spain Transnational?***

The extent to which older British migrants in Spain are transnational has been widely debated. They are often accused of only mixing with other British people and making no effort to integrate into the Spanish community, so of developing an ‘enclave mentality’ (Champion and King, 1993:54). Therefore, social networks are only with other British people and do not include members of the Spanish community. Older migrants often cluster in purpose built tourist and residential complexes, known as ‘urbanisations’ (see *Fig. 2.3.below*), which generally lie outside of historic village centres and have their own shops, restaurants and personal service outlets (Huber and O’Reilly, 2004).

**Fig 2.3 - A Typical Spanish Urbanisation**



Source: Author's own

The extent to which older British people living in Spain mix with the Spanish community has often been found to be minimal. O'Reilly (2004) found that only a third of British people in Spain have Spanish friends whom they meet regularly, whilst around a third do not have Spanish friends. She found that those who are retired are less likely to mix with the Spanish. This is often as a result of an inability to speak Spanish. Many older British migrants especially are not learning the Spanish language to a level that enables them to interact on any more than a superficial level (O'Reilly, 2000a; King *et al.*, 2000; Betty and Cahill, 1997).

However, even though older British migrants may not mix with Spanish people, they have been found to spend their time participating in activities, making friends and building a sense of community (even if this is limited to other British people) (O'Reilly, 2000a). Migrant social activities commonly include participation in British social clubs, from small activity groups to larger and more formal organisations such as the British Legion. Social clubs not only offer a source of enjoyment but present an opportunity to develop social networks, as they provide access to friends and contacts. They also allow people to share information and advice on living in Spain and how to negotiate Spanish bureaucracy. For older migrants, social clubs are often an integral part of daily life, especially for those who are widowed (Betty and Cahill, 1999:90).

Although most clubs welcome all nationalities, language difficulties mean that the members of British expatriate social clubs are generally all British, which can act as a barrier to wider integration (Betty and Cahill, 1997). Research has shown that most members of social clubs are retired and resident in Spain, and most older migrants in Spain belong to at least one club (Rodriguez *et al.*, 1998; O'Reilly, 2000a). A number of clubs have been formed specifically for British people, such as the 'English Speaking Residents Association' (ESRA)<sup>3</sup> in Mallorca or the International Club of Estepona (ICE)<sup>4</sup>, which could be seen to segregate British migrants from the Spaniards and serve to reinforce differences. There are also a number of Spanish organised social clubs, including the 'Pensionista Club', membership of which is available to all Spanish residents of pension age. However, older British people tend to attend British rather than Spanish social clubs (Betty and Cahill, 1997), again indicating their lack of integration with the local community and lack of transnationalism.

Voluntary work also features in the daily lives of older British migrants, along with committee work, organising social events and fund-raising. O'Reilly (2004) found that volunteering often replaces paid work as an activity contributing to a sense of belonging. It can allow older people to maintain active lives and prevent social exclusion (Hardill and Batterbury, 2004). There are a growing number of charities run by British migrants across Spain, such as Age Concern España and Help (see Section 3.6), which are active in providing community services and assistance in emergencies, as well as in organising social events helping people to develop their social networks. However, again these are usually limited to within the British community and can even serve to impede integration.

To be transnational involves embracing both the sending and receiving country and this above discussion would suggest that in fact the majority of older British people in Spain are not fully transnational as whilst they mix with the British community in Spain, they do not mix with or embrace the Spanish community. Whilst this may be due to cultural differences, or the vast network of British activities with which people are engaged, one

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<sup>3</sup> See <http://www.esramallorca.org/>

<sup>4</sup> See <http://www.siberme.com/>

of the biggest barriers to integration is an inability to speak the local language. Huber and O'Reilly (2004) found that a lack of proficiency in the local language can cause significant problems for migrants, including preventing them from socialising with the local community, and joining in with community activities and local politics. It also can cause difficulty navigating local bureaucracy, which can jeopardise the level of service received, especially where technical terms are used such as by doctors and lawyers (see section 3.1.3). A lack of proficiency in the local language by British migrants is most prominent in Spain (Sriskandarajah and Drew, 2006), especially when compared with other countries, such as Italy (King *et al.*, 2000).

It has been argued that since the advent of global communication, especially the arrival of British satellite television in Spain several years ago, the British community has become even more inward looking, as extra barriers have been erected against the infiltration of the Spanish language (O'Reilly, 2007; Huber and O'Reilly, 2004). Some British people in Spain only read British (or English-language) newspapers, watch satellite television and listen to English speaking radio. They also may not watch Spanish television or read Spanish newspapers again indicating that they are not fully transnational. This further excludes British migrants from integrating with and understanding the Spanish community (Betty and Cahill, 1999).

British migrants have therefore been found to maintain strong links and base at least part (or all of) of their identity on connections to the UK (O'Reilly, 2000; Betty and Cahill, 1999). As a result, when a crisis arises, older British migrants may turn to support networks in the UK, rather than those in Spain. Relationships with family members living overseas may be utilised in the provision of care during old age, especially at times of ill health or crisis. Care-giving practices between elderly parents and their children can be maintained despite barriers of distance, especially emotional care. However, this can also be very limited as personal care cannot be provided during times of physical separation (Baldassar, 2007). This thesis examines the transnational relationships of vulnerable older British people in Spain and this includes the extent to which care-giving practices can be maintained especially during times of crisis. It looks at the extent to

which support is obtained from UK and Spanish based (or other) networks. To be transnational would indicate that support can be generated from both UK and Spanish (or other) sources. This includes not only the ability to draw on British friends in Spain for support, but also to be able to turn to the Spanish community to seek help. As discussed above, many older British people do not integrate into the Spanish community or mix with Spanish people. As a result, this would indicate that they are extremely reliant on British sources of support and are therefore not fully transnational. The extent to which older British people in Spain are transnational is explored in this thesis.

Being transnational can also depend on other factors, including social, physical and economic resources. Gustafson (2001) noted that most North-South retirees must be in a financially privileged position in order to fund their transnational lifestyle. O'Reilly (2007) in her study of British migrants of all ages in Spain found that those without sufficient financial resources do not tend to live the fluid and flexible lives associated with transmigrants, as to maintain physical links with family and friends in another country requires enough money to be able to visit them. Duval's (2006) study of Caribbean migrants in Canada applied Grid and Group theory and found that there are a group of migrants who have strong connections with people in their homeland yet are constrained from transnational participation, for example by being financially incapable of travelling. He found that such individuals used alternative methods to maintain their transnational status, including displaying strong diasporic ties with those of a similar origin in the country of migration (Duval's application of Grid/Group theory is discussed further below). Maintaining transnational relationships can therefore depend on economic as well as social and physical resources, for example, some people may not be physically able or have the money or transportation to be able to visit family or friends overseas.



### **2.3 A Typology of Older British Migrants in Spain: The Grid and Group Framework**

This chapter has identified the importance of social networks for the provision of support during old age. The nature of social networks can however be complex and diverse, especially for older people living abroad. In examining the lived experiences of older, vulnerable British people in Spain, this thesis attempts to identify the kinds of support networks that are constructed and accessed in both the UK and Spain (or elsewhere). However, more importantly, it seeks to identify how those networks are utilised in the provision of support and care following the onset of old age or during times of crisis and vulnerability. This chapter has discussed Wenger's (1991, 1997) social network typology of older people which attempts to differentiate between types of social/support networks in old age. However, this typology cannot be directly applied to older British people in Spain as it assumes that most networks are locally based. Furthermore, Wenger's typology looks at the individual whilst neglecting the socio-cultural context within which the individual is located. This thesis attempts to examine the social networks of older British people in Spain, not only at an individual and household level, but within a wider community and socio-cultural context.

This is done through the use of Grid and Group theory (alternatively known as Cultural Theory), which provides a framework to examine the ways in which different people and social groups respond to threats and opportunities (Douglas, 1982, 2005). This thesis focuses on the vulnerability of older British people in Spain in terms of the different challenges or threats they encounter and their ability to effectively cope with these challenges through the mobilisation of social networks. It is also looking at the wider social, cultural and political environments within which individuals are located, including the impact of cultural and language differences, as well as local, national and international policy. Grid and Group theory is highly relevant to this thesis as it goes beyond the individual to look at the wider social environment within which the individual is situated and through which they seek support and help.

According to Baldassar (2007), any analysis of the ‘micro’ factors of transnational research, namely family and other social relationships, must also consider the broader state (macro) and community (meso) contexts. She argues that “these three dimensions inform even the most mundane aspects of transmigrant lives” (2007:278). Therefore, the lived experiences of older British migrants in Spain encompass not only the individual and social, but also the wider community and state. Baldassar’s research focuses on care giving practices and she highlights the importance of state policies and services, community contexts and services, cultural expectations of care, as well as kin relationships which are often fractured by distance. By utilising Grid and Group theory, this thesis is able to identify and examine the micro, meso and macro dimensions of ageing in Spain.

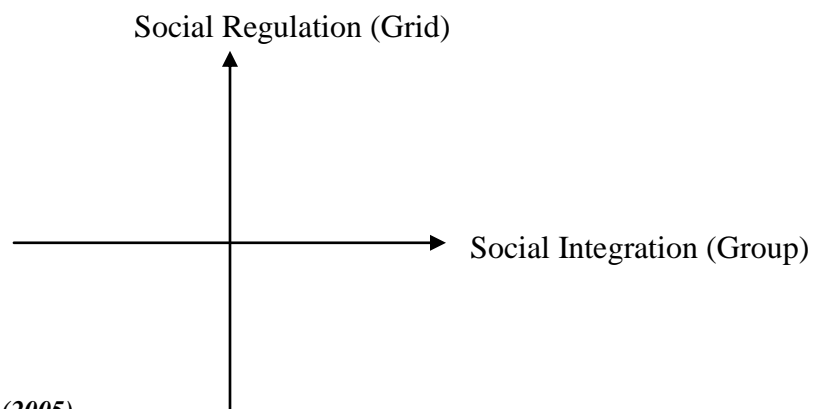
Grid and Group theory has never before been utilised in the examination of older migrant social networks and therefore by doing so, this thesis is making an original contribution to knowledge. The theory has been adapted in this thesis to examine the kinds of support networks that older British migrants construct and access in the UK and Spain (and elsewhere); both formal and informal support as provided by family/friends, the community and state (see Section 2.3.1 for a full explanation of how the theory is used). It also considers the impact of wider social, cultural and political factors on the lives of older British people in Spain.

Grid and Group theory was developed by Mary Douglas to “predict or explain which intellectual strategies are useful for survival in a particular pattern of social relations” (Douglas, 1982:7). It is used to identify different types of social organisation and the values that uphold them. This was based on the work of Durkheim (1951) who introduced the concepts of ‘social regulation’, and ‘social integration’ in order to understand how people’s situations within social organisations shaped propensity to suicide. He drew theoretical conclusions on the social causes of suicide and proposed four types of suicide based on the balance of social regulation and integration; anomic, altruistic, fatalistic and egoistic suicide.

The theory explains the structure of personal relations through two dimensions, which Douglas (1982) labelled ‘Grid’ and ‘Group’. The Group dimension represents social integration or the strength of group ties/bonds (Douglas, 2005). In other words, it looks at the extent to which individuals partake in group rather than individual activities. At one end of the dimension individuals are closely bonded and have strong ties with people, and at the other end are those with individualistic tendencies who have few close ties and little in-group activity. On the other hand, the Grid dimension represents social regulation or the degree to which an individual is “constrained by external rules” (Caulkins and Peters, 2002: 50). It is concerned with the extent to which one’s behaviours are affected by constraints of rules, roles and procedures, such as physical, cultural or institutional regulation. At one end of the dimension an individual is highly regulated, whilst at the other end the individual has a greater degree of voluntary choice.

By combining the Grid and Group dimensions on two axes (see *Fig. 2.4*), four distinct styles of social organisation emerge; each of which are predicted to produce distinct styles of constraint. The result is a cultural map, against which individuals (or groups) can be plotted (Duval, 2006). Whilst there are four types of social organisation, Douglas (2005) recognised that individuals are expected to move, or be forced to move across the diagram, according to choice or circumstances. In addition, some people live under hybrid forms representing settlements between two, three or all four types (Hardill *et al.*, 2007).

***Fig. 2.4 - Grid and Group Diagram***

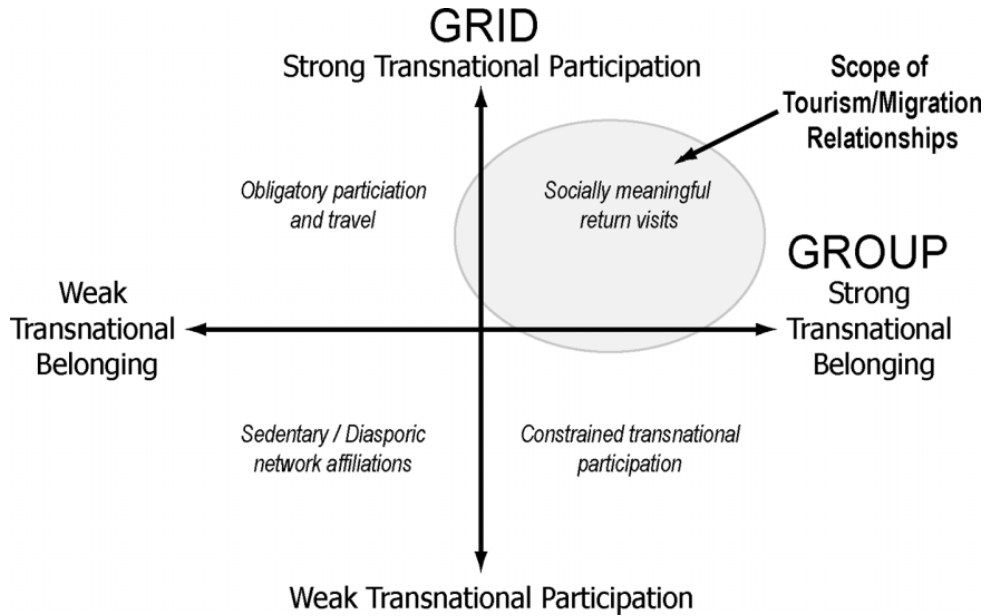


*Source: Adapted from Douglas (2005)*

A salient feature of grid and group theory is its malleability (Duval, 2006) and as such it has been used and adapted by many academics. This includes 6 (2004) who used it to identify distinct forms of personal social networks, in particular friendship patterns. It has also been used by Hardill *et al.* (2007) to explain patterns of and motivations for volunteering, whereby the type of volunteering in which people engage might be explained by the patterns of social organisation and social networks in which people find themselves. Grid and Group has also been applied to migration studies by Caulkins and Peters (2002) who looked at entrepreneurship and social capital among immigrant groups in the USA, and by Duval (2006) who applied the theory to examine links between migration and tourism.

Duval's (2006) adaptation of the theory has some relevance to this thesis, as he explored the underlying social context of transnational mobilities, in particular the reasons why migrants return to their homeland. He used the Grid dimension to refer to the strength of transnational social bonds, i.e. participation in transnational activities. The Group dimension refers to transnational belonging or "how much a migrant's world view encompasses more than their current place of residence" (Duval, 2006:8) and includes the degree of obligation felt by migrants to return to their homeland. The result is a conceptualisation of how migrants might organize their transnational social spaces and time (shown in *Fig. 2.5*). High grid and group refers to those with strong transnational tendencies; high grid, low group refers to those who are transnational more out of obligation than choice; high group, weak grid are those whose transnational participation is constrained for example due to financial limitations; and low grid and group refers to weak transnational participation. Duval is the only notable author who has used Grid and Group theory to examine international migration and transnationalism; however, he used it to explore the relationship between migration and tourism rather than examining the social and support networks of migrants as this thesis does.

**Fig. 2.5 – Duval’s Grid and Group Diagram**

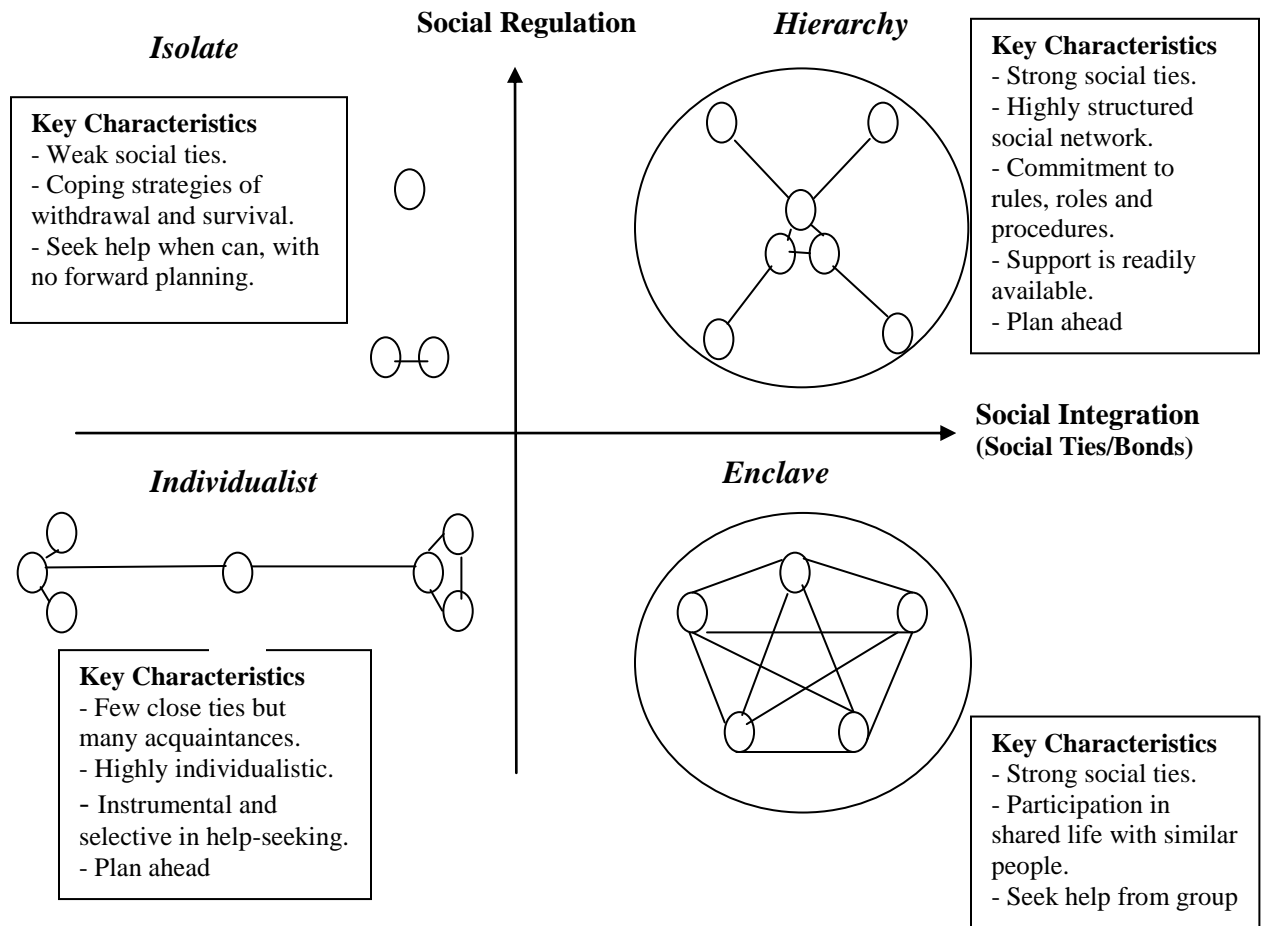


*Source: Duval (2006:7)*

### **2.3.1 Using Grid and Group to explore the lived experiences of vulnerable, older British people in Spain**

Through the use of Grid and Group theory, this thesis attempts to categorise the different responses that older British people in Spain have to vulnerability and how they cope in the face of a crisis. It looks at social network configurations and how these are used to generate support, as well as the extent to which they engage in forward planning in order to reduce vulnerabilities and the onset of a crisis. It also examines the different types of constraint impacting upon their lives, including from the wider community and state. The framework therefore encompasses the nature of group bonds (e.g. with family, friends, neighbours and community groups) and the impact of institutional, social and cultural regulation (e.g. the impact of laws, regulations and policy), to capture four distinct types of social organisation; Isolate, Hierarchy, Enclave and Individualist (detailed in Fig. 2.6).

**Fig. 2.6 – Grid and Group Diagram**



*Source: Adapted from Hardill, Baines and 6 (2007:401)*

In the top right quadrant, high grid and high group has been labelled “Hierarchy” (6, 2004) (or “Positional” by Douglas, 2005) and refers to a highly integrated and regulated context. The good of the group is placed over the good of the individual and as such competition is discouraged. It has a highly structured form with people having clear roles in relation to each other, and decision-making roles are clearly located at the top. Such people “...favour tradition and continuity...must encourage respect, loyalty, obedience and the well-being of the community...and take the long term into account” (Douglas, 2005:7). This group therefore frequently engage in forward planning by thinking ahead about possible crises. They may have strong links with formal organisations which could be referred to as linking social capital, as it describes people coming together with those

outside of their normal social circle, in particular those who do not have power with those who do and as such support is readily available (Douglas, 2005). The social network type presented here is most representative of Wenger's social network type 1 and type 5, where people are well integrated with a high level of community and group involvement. This is therefore also indicative of bridging social capital, as networks encompass people across diverse social groups (Putnam, 2000). Hierarchy types could include migrants who have strong links with both the host country and the country of origin, so have strong transnational participation. This corresponds with Duval's (2006) use of the theory. However, by applying the grid dimension, Hierarchy types adhere to the rules and procedures of local, national and international policy. They are therefore strongly regulated through formal constraint mechanisms.

In the bottom right quadrant, high group and low grid refers to strong integration but weak regulation and has been termed "Enclave" (Douglas, 2005). This refers to groups that have strict rules, who regulate their contact with the outside and avoid social differentiation within the group (Douglas, 2005). Social networks are heavily concentrated to ties with people in the immediate locality, and historically, this configuration has been found most common in long-established working-class communities, or ethnically homogenous neighbourhoods (Hardill *et al.*, 2007). This could therefore include migrants who do not integrate into the local community and mix only with other people of the same nationality i.e. the "enclave mentality" (Champion and King, 1993:54). This type of social network configuration can be linked with bonding social capital, as it refers to the relations between homogenous groups, and as a result tends to reinforce exclusive identities (Putnam, 2000). It could also be linked with Wenger's network Type 3, where help is sought from within the family (or group) rather than from outside. They have therefore withdrawn from external/formal regulation and instead regulate themselves through informal mechanisms and in-group membership leading to self-imposed constraints. As a result, they engage in little forward planning and have a limited amount of support.

In the bottom left quadrant, low grid and low group has been labelled “Individualism” (Douglas, 2005) and means both regulation and integration are weak. From this emerges a competitive and individualistic culture where the well-being of the individual is greater than that of the community. Such people would reject the enclave mentality in favour of a more individualistic one. The prominent virtues are individual courage, intelligence, perseverance, and success (Douglas, 2005). Whilst such people may not have vast social networks, they may have many acquaintance-like connections with people who are sparsely connected, who they can use in quite instrumental ways to seek out information, opportunities and social status (Hardill *et al.*, 2007). In terms of social capital, individualistic tendencies could be linked with bridging social capital and could include migrants who have links with both British and Spanish people/institutions and through the use of informal mechanisms, are able to negotiate the best deal for themselves. They may look to the future and plan ahead for any eventuality. They are however somewhat self-constrained due to their rejection of the ‘group’.

Finally, in the top left quadrant, high grid and low group refers to the strongly integrated but weakly regulated group who have been termed “Isolates” (Douglas, 2005). They have few social ties and limited networks other than a few longstanding friends, neighbours or family members (Hardill *et al.*, 2007). They are heavily constrained by formal rules and regulations. They have been argued to be lacking in any form of social capital and should be understood as a form of social solidarity who sustain coping strategies for survival using any resources or opportunities they encounter (Hardill *et al.*, 2007). They are therefore unable to engage in forward planning. Conventions prevent such people from joining groups, perhaps because they lack qualifications, have the wrong accent, not enough money, or the wrong schooling (Douglas, 2005). This group could include migrants who have few ties to either British or Spanish people/institutions, and as such support is minimal. Either through choice or constraint their transnational participation is minimal. This differs significantly from Duval, whose high grid, low group position indicates those who are transnational out of obligation. This group could be linked with Wenger’s social network type 4, as they have a lack of informal support and instead rely on any formal resources available to them.



This typology is the heuristic framework being used for the analysis of the social networks of interview respondents in this study. It is being used to categorise the experiences of older British people in Spain, in particular to highlight the different challenges and vulnerabilities encountered and how effectively individuals are able to cope with those vulnerabilities through the mobilisation of their social networks. As a device used to examine the socio-cultural context of individuals, it is also being used to examine the extent to which vulnerable older British people in Spain are transnational, especially at times of crisis. The framework has captured the four distinct types of older British people in Spain identified above; Isolate, Hierarchy, Enclave and Individualist. These four types are explored and discussed in Chapter Five.

## **2.4 Summary**

This chapter has examined the literature on old age vulnerability, social networks and support. It has shown how old age may be characterised as a time of decline where additional support is required to retain independent living. It has highlighted the characteristics of older people's social networks and the ways in which they can be mobilised in the provision of support and care. It has also looked specifically at the social networks of older British people in Spain and the extent to which such individuals are transnational. This chapter has also introduced the theoretical framework that is being taken forward in this study, Grid and Group, which is being used to categorise the lived experiences of older British people in Spain.

In the following chapter, more formal sources of support for older British migrants in Spain are examined. As shown in Section 2.1, health and financial challenges are particularly common during old age, so the next chapter reviews the healthcare, social care and welfare rights of older British people in Spain. It also examines the nature of health, social care and welfare support services in Spain and the extent to which they are accessed by older British migrants.

## **Chapter 3 – Ageing in Spain: Support from Health, Care and Welfare Services**

This chapter examines the impact of UK, Spanish and EU policy on older British people in Spain, focusing on rights to healthcare, social care and welfare support services. As this thesis is about the lived experiences of older, vulnerable British people living in Spain, access to healthcare, social care and financial support can be vital to ensure well-being and quality of life. Whilst good social networks can reduce vulnerability and improve overall wellbeing, a significant health or financial difficulty usually requires access to formal health, care and welfare services.

This chapter therefore discusses the health, care and welfare rights of older UK nationals who are living in Spain. It also looks at the availability of such services in comparison to the UK, as well as the difficulties older British people may face when accessing and using these services. It also addresses the rights of older British people to return to the UK after living in Spain. The chapter then concludes the literature review section of this thesis by outlining the main challenges and areas of vulnerability facing older British people when they move to Spain before summarising the main sources of help and support that are available to them, including the services of Age Concern España with whom this research was undertaken.

### **3.1 Healthcare in Spain for Older British People**

As discussed in Section 2.1, a significant determinant of vulnerability in old age is health. A decline in health is particularly common during old age and can considerably reduce quality of life (e.g. Grundy, 2006). Therefore, the ability to access good healthcare

services is often vital following the onset of old age. Healthcare refers to all medical support, including the treatment of physical and mental health problems. This includes the use of hospitals and primary care services e.g. GPs and district nurses. As a result of health problems, social care is also often required, and this is examined in Section 3.2. This section therefore looks at the development of healthcare services in Spain, as well as the rights of older British people to access them.

### ***3.1.1 Healthcare Services in Spain***

In the post-Franco period, the quality and variation of healthcare available in Spain has increased dramatically. Following the creation of the Ministry of Health in 1977 and the General Health Care Act in 1986, a national health service was created. By the 1990s, universality of provision free at the point of delivery had been achieved (King *et al.*, 2000). By 2002, although the Spanish social security system (Seguridad Sociale) has been retained at a national level, the compulsory health insurance system (El Instituto Nacional de Salud) was decentralised and healthcare is now provided by the 17 autonomous regions in Spain. Therefore, it is not possible to speak of a unified health system, but instead of seventeen regional health services, with the national Ministry of Health assuming a coordinating role through the *Consejo Interterritorial del Sistema Nacional de Salud* (CISNS) (Rosenmoller and Lluch, 2006). Under this system, rights to healthcare are guaranteed for all Spaniards and foreign citizens resident in Spain (with some exceptions for retired migrants discussed below). The only costs for patients can be up to 40% of the cost of prescriptions (except for pensioners who receive free prescriptions) and there are charges for dental and psychiatric services. However, as each autonomous region has its own health network, health legislation and health plan, the level of care can differ between regions.

The quality of Spanish healthcare is often considered to be excellent (Age Concern España, 2006b; King *et al.*, 2000), often with shorter waiting times for non-emergency treatment and better quality hospitals than in the UK. For example, in most Spanish

hospitals there are only two people to a ward. However, despite some major achievements the Spanish health service, like the British NHS, does have problems such as long waiting lists, insufficient beds and a shortage of nurses (King *et al.*, 2000). There are also different cultural practices in Spain compared to the UK. For instance, in hospitals, it is customary for the patient's family to provide basic nursing care, by undertaking duties such as feeding and washing the patient, whilst in the UK such duties would be performed by nursing staff (Age Concern España, 2006b). Aftercare can also be sparse in Spain, as there is a "virtual absence of community health services" (King *et al.*, 2000:183). Therefore, whilst hospital care is very good, hospital nursing is very different to the UK and there is little support following discharge. The distribution of services can also vary by region, for example beds are also unevenly distributed, being scarcer in rural areas and in the South (Age Concern España, 2006b; King *et al.*, 2000). Therefore, area of residence can greatly influence healthcare availability and in a similar fashion to the UK, many people have turned to the private sector.

### ***3.1.2 Accessing Healthcare in Spain as a Retired British Migrant***

Obtaining healthcare in Spain can be difficult for retired British people, and the level of cover available can vary according to individual circumstances, such as the age at which migration occurred and whether the individual (or their spouse) has worked in Spain. There have been cross-national health campaigns within the EU encouraging co-operation between members on general health matters. However, the EU is not a welfare state so in reality rights and entitlements depend "on national laws and the systems operating in individual member states" (Dwyer, 2001:315). In addition, the British government does not have to provide healthcare for all British citizens living outside of the UK (except under certain reciprocal arrangements discussed below) and The Department of Health issued a statement which said;

If someone wishes to live outside the UK, the NHS – which lives within limited resources – may not have a responsibility for their healthcare costs under law (cited in ITV, 2007).

As a result, access to healthcare for older British people in Spain is varied, and many have little awareness of their rights (Coldron and Ackers, 2007). There are five main ways in which healthcare can be obtained and these are summarised in *Fig. 3.1* on the next page. In Spain, retired migrants must be covered by sickness insurance of some kind to have a right to residence. This can be obtained either through private healthcare or via reciprocal arrangements existing between EU member states (then any costs of healthcare are recoverable against the country of origin). Alternatively, retired migrants who have worked in Spain are entitled to the same level of cover as a Spanish national.

A UK state pensioner (over 60/65 years) who is a resident in Spain, can obtain free healthcare via a reciprocal arrangement existing between the UK and Spain (through an E121). Under this system, rights to healthcare in the UK are transferred to Spain. British people who are below state pension age (SPA) can also become eligible for medical cover under the E121 as dependants on their spouse reaching SPA i.e. the spouse of women over 60 or men over 65 are entitled to free healthcare. In addition, those who are in receipt of incapacity benefit (regardless of age) may also be entitled to free healthcare under the E121. Therefore, those who have reached SPA, have a spouse of SPA or are in receipt of incapacity benefit in Spain are able to receive free healthcare.

Under EU reciprocal healthcare arrangements, travellers from member states are entitled to free or reduced cost emergency treatment in all EU countries on production of a European Health Insurance Card (EHIC) (the EHIC replaced the E111 in 2006). However, this can only be used for temporary visits to other EU countries and not by people who choose to live abroad (Foreign and Commonwealth Office, 2010). Alternatively, an E106 can provide temporary healthcare cover for up to two years, providing National Insurance contributions have been made in the UK for the previous three years. Once the E106 runs out i.e. after two years, those who are not of SPA are not

entitled to free healthcare via reciprocal arrangements with the UK. Consequently, British migrants living in Spain who are under state retirement age, who have not worked there, have no automatic right of access to free extended healthcare in Spain<sup>5</sup>. They therefore do not have any formal social citizenship rights in relation to healthcare.

***Fig. 3.1 - Accessing Healthcare in Spain***

<b>Type of Healthcare Arrangement</b>	<b>Level of Cover</b>	<b>Source of Funding for Healthcare</b>
Reciprocal via EHIC	Emergency healthcare in Spain for temporary visits only.	UK government
Reciprocal via E106	Full healthcare for up to 2 years dependent on NI contributions.	UK government
Reciprocal via E121	Free healthcare in Spain for those of SPA.	UK government
Healthcare via status as a worker in Spain	Free healthcare in Spain.	Spanish government
Private health insurance	Depends on individual policies.	The individual according to their healthcare policy.

Conversely, whilst some British citizens living in Spain are not entitled to any state funded healthcare, British citizens who are resident in the UK may be entitled to travel to another EU country to receive healthcare under the British NHS. Using an E112 form or under case law developed in the European Court of Justice (Watts case, Article 49 EC Treaty), an NHS patient can receive hospital treatment in another EU country if they face “undue delay” or need a service that would not otherwise be funded in the UK (DoH, 2007b). Furthermore, an EU Directive on cross border healthcare has been proposed by the European Commission, meaning that it will be easier for patients to receive healthcare in member states (European Commission, 2010). Whilst this may make it easier for

<sup>5</sup> In some areas of Spain (such as parts of Valencia), exceptions may be made regarding healthcare arrangements, whereby those who are under state retirement age are entitled to free healthcare. In most cases, this is subject to certain conditions being met and a yearly application to the local authority area.

migrants in Spain to receive healthcare in the UK, as well as UK residents (including seasonal migrants) to receive healthcare in Spain, it will not allow early retired British migrants to receive long-term healthcare in Spain.

There are therefore a diverse range of situations with regards to the healthcare entitlements of older British migrants. A number of commentators have identified different ways in which older British migrants are exercising their healthcare rights abroad. This thesis draws on three distinct ways migrants are accessing healthcare as outlined by Coldron and Ackers (2007). Their findings were based on research by Ackers and Dwyer (2002) on older EU migrants in six different countries (excluding Spain), as well as Coldron and Ackers own research on British migrants (of all ages) in Spain. These studies identified the following three ways in which migrants exercise their healthcare rights:

1. *Rely solely on private health insurance.* By exercising their rights as active consumers, this group are able to opt out of any public healthcare rights and instead use their personal wealth to pay for healthcare providing them with the greatest degree of flexibility. Social citizenship and healthcare rights only become relevant when their money runs out or when private healthcare insurance does not cover long-term care. Ackers and Dwyer (2002) found only 10% of their sample relied solely on private healthcare. This may include early retirees who cannot access publicly funded healthcare in the host country.
2. *Rely on public healthcare.* This group export their health insurance entitlements abroad and use public healthcare services as legitimate citizens after registering their residency in the host country. The majority of participants in the two studies relied upon public healthcare. This group may however exclude early retirees who cannot export their healthcare rights to the host country.
3. *“Illegitimate use” of Healthcare Services.* Coldron and Ackers found some migrants to exercise their healthcare rights by manipulating their residency status in the

country of origin and/or the host country. This was through the conscious non-reporting of residency as: (1) ‘false tourists’ in the host country by using the EHIC to ensure access to publicly funded healthcare; and as (2) ‘clandestine migrants’ in the country of origin by not declaring a change in residency to retain access to public healthcare. By manipulating the system, such migrants receive the best healthcare coverage to meet their needs. The authors cite this approach as “the darker side of active citizenship” (Coldron and Ackers, 2007: 299), as it has serious implications for the financing of state-funded healthcare systems.

Further to these three ways of accessing healthcare, Dwyer (2001) notes that retired EU migrants may maximise their rights by using a mixture of public and private healthcare. Those who choose private healthcare in the country of migration may legitimately retain rights to public healthcare in the country of origin by returning temporarily to satisfy conditions of residency. In addition, some migrants also return permanently to the country of origin when the need for long term care arises. This does not involve non-reporting of residency in either the host country or country of origin and is therefore a more legitimate option than that cited by Coldron and Ackers. Furthermore, retired EU migrants may exercise their rights to access public healthcare in any member state; however they also have the option to opt out of it and exercise their rights as consumers of private healthcare policies. The choice to opt out in and out of public/private healthcare is often dependent upon healthcare provision in the country of residence (Dwyer, 2001). Many North-South migrants, including older British people in Spain, may choose to opt for private healthcare in Spain due to concerns about poor levels of public provision or the nature of healthcare services (Dwyer, 2001). As shown in Section 3.1.1, healthcare can differ between Spain and the UK, and also between regions in Spain, something that migrants should take account of when making a decision to move.

The exercising of healthcare rights can also be dependent on other factors. Coldron and Ackers (2007) found that the choice of healthcare can depend on social context, as changes in personal circumstances, such as a decline in health or bereavement, often led participants to reassess their access to healthcare. Decisions about accessing healthcare



can also be influenced by variations in the financial resources of migrants, in particular whether they can afford private healthcare. Hardill *et al.* (2005) also point out that private health insurance premiums can increase in line with age and medical needs. Private health insurance packages can also be of limited use when the need for long term care arises (Dwyer, 2001).

### ***3.1.3 Healthcare and Language***

An additional barrier for older British migrants looking to access healthcare services in Spain is the local language. This can lead to isolation and compound existing challenges, and this is especially true when it comes to healthcare. The previous chapter identified that many older British people in Spain do not speak Spanish. Research conducted in the Costa del Sol shows that language is a significant problem for British people living there with most only being able to interact on a superficial level (O'Reilly, 2000; King *et al.*, 2000). Furthermore, research by the Spanish Society of General Medicine (cited in Stevens, 2006) found that fewer than ten percent of expatriates in the Spanish Costas can communicate with medical staff and almost a third rely on hand gestures, indicating the sheer scale of the problem. Even those who have a good understanding of the Spanish language are unlikely to understand complex medical terminology needed for a visit to the doctor or when receiving hospital treatment. It is especially important to fully understand what someone is being told when it comes to health and healthcare, and misunderstanding information from doctors can be potentially life threatening, for example by taking the wrong medication. There are some initiatives to assist people with medical terminology, such as the 'Tell the Doctor' book, which was published in Alicante and available from Age Concern España organisations for a small fee. This covers most illnesses and symptoms and provides basic phrases needed when visiting the doctor; however, it does not enable someone with no Spanish-language skills to hold a conversation with a doctor.

Furthermore, reports have found that some Spanish doctors are refusing to speak English. They will not treat anyone who cannot speak Spanish without an interpreter present, as the doctor would be held responsible for any misunderstandings (Stevens, 2006). Therefore, many people are required to hire a translator when they visit the doctor, which can be very costly, especially for those who require long-term medical interventions. La Parra and Angel Mateo (2008) found that language problems in the public healthcare sector may also be the reason for a high use of private healthcare by British people in the Costa Blanca; however, this can be more expensive than paying for translators. He found that around 29% of British people (of all ages) in Spain have private health insurance. This may be lower among older British people due to higher insurance premiums (Hardill *et al.*, 2005)

Therefore, limited Spanish language skills can pose major problems when it comes to accessing healthcare. Hardill *et al.* (2005) found that accessing and receiving health and social care pose the greatest problem when a migrant speaks little or no Spanish. Language can act as a barrier to accessing healthcare, support from Social Services and nursing home care. Even if care can be accessed, finding a nurse, carer or care home that speaks English is difficult. An inability to communicate can exacerbate existing problems, and for people with physical and mental health problems such as dementia, it is especially important that the carer is able to speak their own language. The chapter now moves on to discuss care in more detail, looking at the rights of older British people to access social care in Spain and the nature of social care services, including nursing homes in Spain.

### **3.2 Social Care in Spain for Older British People**

Whilst healthcare refers to medical support, social care refers to the protection, support or advocacy of vulnerable or dependent people. Social care in both Spain and the UK is a 'mixed economy' and lies at the intersection of the public and private; paid and unpaid;

and formal and informal (Daly and Lewis, 2000). Social care has been defined by Kröger (2004: 3 cited in Perista, 2009) as:

... the assistance and surveillance that is provided in order to help children or adults with the activities of their daily lives. Social care can be paid or unpaid work provided by professionals or non-professionals, and it can take place within the public as well as the private sphere. Formal service provision from public, commercial and voluntary organisations as well as informal care from family members, relatives and others, such as neighbours and friends, are included within social care.

Social care is therefore not just the responsibility of the state and is often provided by informal support networks, especially family. As shown in Section 2.2.2, the nature of care and support from family, friends and neighbours can vary, with family being more likely to provide intimate or primary care (Lynch, 2007). However, as noted by Perista (2009), migration can dislocate traditional forms of support, as it can create large geographical distances from relatives and friends. For older British people in Spain, children and other close family may be living in another country (most likely the UK), so are not available to provide care. As a result, migrants may be more likely to rely on more formal sources of support as provided by the Spanish welfare state or British/Spanish voluntary services based in Spain. However, in Southern Europe care is often provided by family members rather than the state, and although this tradition is in decline, the result is that Social Services in Spain are less well established than in most developed countries (Defensor del Pueblo, 2000 cited in Rogero-Garcia et al., 2008), including the UK.

Across Spain, the family and church were virtually the sole providers of Social Services until well into the 1970's (during and before Franco's era), and to a great extent social care is still expected to be provided by the family today. In most of Southern Europe including Spain, the care of dependent elderly people is private and the responsibility of the nuclear and extended family (Da Roit, 2007) and is not usually recognised as an

activity to be covered by the public system. As a result, more than 65% of care for older people in Spain is provided informally by family members (Ministry of Labour and Social Security, 2005, cited in Costa-Font and Anna García González, 2007). In addition, 83% of dependent older people in Spain receive informal care from family, which is 30% more than in the UK (Costa-Font and Patxot, 2005). Comparatively, in the UK, the state is still to a great extent expected to finance social care services for older people. Whilst social care is means-tested, in 2007/8 around 1.2 million people over the age of 65 received social care that was provided or funded by the UK welfare state (Poole, 2009). There are therefore significant cultural and social differences between Spain and the UK, with social care often being compared unfavourably in Spain (Betty and Cahill, 1999).

It was not until the arrival of democracy in Spain after 1975 that a unified social security system was developed. Social care responsibilities are not just at a state level, but at the level of the 17 autonomous regions, meaning that there are considerable differences in services between regions (Tortosa and Granell, 2002). Access to social care is not universal, but the government does assist people with low incomes and high levels of dependency (Sancho Castiello and Diaz Martín, 2006 cited in Rogero-Garcia *et al.*, 2008). There have been a number of developments in Social Services in Spain over the past few decades, including the development of the National Institute of Social Services in 1978, as well as a reform of primary care services in 1984 to introduce multi-disciplinary team practices at health centres (King *et al.*, 2000).

Furthermore, in January 2007, the Personal Autonomy and Dependent Care Law (39/2006) came into effect in Spain with the purpose being to extend services to people who need support, due to illness, disability or old age (Eurofound, 2009). Additional services are being introduced over an eight year period, mainly to help those with severe care needs. More money is being put into formal provision for those requiring long-term care, including home help, day and residential care and support for carers (Costa-Font and Anna García González, 2007). This has come at a time when informal family care is in decline due to de-traditionalisation and increasing mobility in Spain, which has caused a greater dislocation of the family (Da Roit, 2007). Traditional large family units are

being fragmented, female labour market participation has risen and greater emphasis is placed on paid work resulting in less availability of unpaid family care (Tarricone and Tsouros, 2008). Family are now less able and willing to provide care for family members than they used to so as a result, there is a greater reliance on the Spanish welfare state to both provide and fund care. Some services have therefore been developed as a response to this.

Spanish Social Services now provide a range of care services including homecare services, day-care centres, telecare at home, and rest homes for seniors (Rogero-Garcia *et al.*, 2008); however, there is still a supply shortage in many areas as well as limited community services. For example, District Nursing services may be rare or non-existent (Age Concern, 2005). Therefore, although Spain has ambitious Social Service and community development policies, there has not been widespread implementation (King *et al.*, 2000). The role of private and voluntary organisations can be crucial to fill these gaps in local health and care systems. This is particularly the case for older British migrants due to language barriers restricting access to those services that are available.

There has therefore been an expansion in the privatisation of care across Southern Europe, with private expenditure on institutional and community care in Spain being around 73% of the total expenditure (Costa-Font and Patxot, 2005). An extensive care market has developed in Spain and commercial solutions to elderly care needs have occurred. From the end of the 1990's in many Southern European countries, a growing number of elderly people were being cared for by paid care workers (Da Roit, 2007). Care workers can provide anything from occasional help with personal support or household duties, to 24 hour care, possibly in the form of a live-in care worker. There has been a considerable expansion of the 'grey' economy of care by a growing number of illegal immigrants who provide home care in Southern European countries but receive an informal salary and do not pay taxes. This can include live-in carers who provide 24 hour care (Tarricone and Tsouros, 2008). These may even be paid for by care allowances or personal budgets (Tarricone and Tsouros, 2008). Whilst domestic care in Southern European countries is relatively cheap compared with Northern European countries, long

term care however can be expensive. Older migrants on a fixed income may not have sufficient financial resources to pay for long term or intensive private care.

Residential care has expanded in Spain; however, places in state homes are very limited with figures showing that places accommodate only 1.26 percent of the older population in Spain (Sancho Castiello, 2002 in Hardill *et al.*, 2005). Eligibility criteria for public nursing homes is based on income and need, however varies from one region to another (Costa-Font and Patxot, 2005). On the other hand, the British Consulate (2006) estimate that private homes cost from 1500 to over 5000 euros a month and therefore may be too expensive for most migrants. Whilst state homes are funded primarily by the government, people must pay a contribution, which tends to be a certain percentage of their state pension. The cost of care homes is dependent on income, whereby people with a lower income pay less than those with a higher income. Even for those who can afford to pay for nursing homes, finding one where English is spoken may be difficult (Hardill *et al.*, 2005). Furthermore, the internal culture may be so different to that experienced in the UK that they may become an unviable option for older British people, especially those who cannot speak the language and are not integrated. Some countries are recognising the need for foreign-owned (and speaking) nursing homes, for example Dutch-owned private nursing homes are being built (Rosenmoller and Lluch, 2006), as well as Norwegian geriatric and rehabilitation centres which are run by Norwegian municipalities and staffed almost entirely by Norwegians in the Alicante area (Fuchs, 2007). However, there are very few, if any, British facilities that cater for the needs of British citizens.

The need for both health and social care increases during old age, as dependency and vulnerability increase. Older British migrants may be especially likely to need formal care support, as they have usually moved away from family and as such have limited informal support networks in Spain. However, as the above discussion suggests, the provision of health and social care in Spain can differ from the UK and access can also be dependent on rights. Furthermore, language barriers can impede access to services even further. Some Spanish authorities have recognised the need for services for foreign

residents, so have introduced, for example, British/English speaking Social Workers (British Consulate, 2006). However, services remain limited and private care may be the only option. It is therefore essential that older British people in Spain plan ahead for old age, especially in relation to health and social care. Vulnerability is about the ability to cope with challenges when they arise and for older people, a decline in health and the need for additional care are often the most significant challenges they can face (Grundy, 2006). Therefore, in order to reduce vulnerability during old age, forward thinking about access to and the availability of health and social care provision can be vital to avoid a crisis. Without such planning, a return to the country of origin is often necessary (Age Concern, 2007). Returning to the UK is discussed further in Section 3.4.

### **3.3 Welfare and Residency Rights in Spain**

#### ***3.3.1 Pensions and Welfare Benefits***

Economic factors feature very highly in the reasons for migrating to Spain, in particular acquiring a better standard of living through cheaper living costs, including lower house prices, lower heating costs and the cheaper cost of eating out (Rodriguez *et al.*, 1998; O'Reilly, 2000a). Ackers and Dwyer's (2002) research found that some EU migrants who moved post-retirement were able to maximise the financial advantages gained through a move to Southern European countries. This includes the benefits gained from cheaper living costs, as well as fiscal and tax policies (Williams *et al.*, 1997). Research on EU retirement migration shows that most Northern Europeans who move to Southern Europe are in an already relatively privileged financial position so are not reliant on Social Security benefits or pensions for their income (King *et al.*, 2000; Ackers and Dwyer, 2002). However, whilst King *et al.* (2000) found that nearly two-thirds of retired British migrants in Southern Europe were from social class groups one and two (professionals and managers), they also found many from lower social classes, indicating

that less wealthy working class British people are moving to Southern Europe. Such people may be moving to seek economic advantages such as lower living costs.

Whilst living costs in Spain have remained lower than in the UK, economic conditions are subject to sudden changes either at an individual or wider economic level. Economic and policy changes can negate all economic advantages of moving abroad. The current economic crisis for example, has resulted in a substantial decline in the value of the UK pound against the Euro. As a result, the value of the state pension (when converted into the euro) is now worth approximately 30% less than it was a few years ago and the interest paid on any savings has also considerably declined (Davys, 2009). This has led to financial difficulties for some older British migrants in Spain (Britishexpats, 2008; Toorney, 2009). In addition, changes in individual circumstances, such as the depletion of savings, the death of a spouse, or the need for care can diminish financial resources and cause a need for social security benefits (King *et al.*, 2000). Furthermore, there are a growing number of older British migrants who rely solely on their state pensions for financial security (King *et al.*, 2000).

Under EC Regulation 883/2004<sup>6</sup>, the state pension of a British national is exportable should they relocate within the EU. Annual increases in the state pension are also available. Therefore, the state pension is not affected by a move within the EU. However, most other welfare benefits are not available when a British citizen moves to Spain; from either the British or Spanish governments. The UK provides more welfare benefits than many other European states, including Spain. In Spain, the payment of most benefits is made by the Instituto Nacional de la Seguridad Social (INSS) and benefits are primarily for those who have worked in Spain and are based on contributions. Therefore, retired British people who have not undertaken paid employment in Spain are not entitled to such benefits. Those of working age (18 to 65), who cannot work due to a disability, can claim a non-contributory incapacity benefit in Spain. However, this only applies to those who have a low income and have been legally resident in Spain for at least five years, including two years preceding the claim

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<sup>6</sup> Replaced EC Regulation 1408/71 in May 2010.



(Ministerio de Trabajo y Asuntos Sociales, 2007). After 65 the Spanish state retirement pension is paid to those who have worked in Spain for fifteen years, two of which must have been in the fifteen years prior to retirement.

Although EC Regulation 883/2004 makes some UK benefits exportable, this is generally limited to benefits based on National Insurance contributions, and includes:

- *Incapacity Benefit* – providing adequate National Insurance contributions have been paid.
- *Bereavement Benefits* – includes a bereavement payment and bereavement allowance for those under SPA
- *Winter Fuel Payments* - available to those who moved to Spain after 1998 and were over the age of 60 at the time of moving.
- *Benefits for accidents at work and industrial diseases.*

In October 2007, the European Court of Justice ruled that Attendance Allowance, Disability Living Allowance (care component only<sup>7</sup>) and Carers Allowance are also exportable within the EU (Directgov, 2008). Therefore, British nationals in receipt of these benefits in the UK can continue to receive them when they move within the EU. However, at the current time, these benefits cannot be initially claimed from abroad and therefore anyone who becomes ill or in need of additional care whilst living in Spain cannot claim financial support.

Benefits that are not exportable are:

- *Pension Credit* - is listed in Annex X of Regulation 883/2004 as a special non-contributory benefit.
- *Housing Benefit and Local Housing Allowance* - based on current UK income so are not exportable.

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<sup>7</sup> The DLA is made up of two components: a care component for those who need help looking after themselves or need supervision to keep them safe; and a mobility component for those who cannot get around by themselves (Directgov, 2008).

- *Direct Payments* – (see below)

Direct Payments are a social care payment paid by a Local Authority Social Services department in place of direct care provision. It is for individuals to purchase their own care services (DoH, 2008). Direct Payments are not exportable within the EU but can be paid for up to six months abroad. It has however been argued that Direct Payments should be available to British nationals living abroad. For example, the National Centre for Independent Living made a statement saying that they could be adapted for people living abroad without breaching any of the laws governing them, whilst Richmond Borough Council said that they were looking into paying Direct Payments to those who move abroad (MacErlean, 2007). It therefore appears that Direct Payments may be a good way to provide care services for British citizens living in another country. Care allowances or personal budgets may already be used to purchase private care at home, including live-in carers (Tarricone and Tsouros, 2008). The lower cost of care services in many EU countries, including Spain, may also mean that the payments would be lower than the equivalent in the UK. Furthermore, older people often move abroad to reduce the negative effects of illnesses and disabilities due to the better climate (Rodriguez *et al.*, 1998), so living abroad may in itself reduce care needs.

An inability to export some benefits abroad has been noted as contributing to the financial hardship of older British migrants (Age Concern, 2007). A lack of financial planning has also been identified as a cause of financial difficulty, as for instance, some people move without knowing which benefits are exportable, leaving them with financial problems (Age Concern, 2007). This appears to have been recognised by the government who in 2007 introduced a new support and liaison team, funded by the DWP and based at the British Consulates in Alicante and Malaga. They provide information and advice regarding pensions and benefits, as well as on registering for healthcare (Foreign and Commonwealth Office (FCO), 2007). However, they do not provide any financial help, or health and social care services. Other foreign nationals receive similar help, for instance the Dutch government have appointed a Social Attaché at their Madrid Embassy to offer advice on pensions and benefits (Sociale Verzekeringsbank, 2009).

### ***3.3.2 Residence Cards and Rights to Residence***

Legally, if someone lives outside of the UK for more than six months of the year they are no longer considered a resident of the UK. Therefore, a British national who spends more than six months of the year in Spain must become a legal resident of Spain. This means registering at a local Foreigners Department or Police Station, where a registration certificate is issued (in March 2007 residency rules were relaxed so that migrants no longer have to apply for a Community Residence Card) (FCO, 2008). Once resident in Spain, rights to healthcare, social care and social security are transferred to Spain. However, as discussed above, rights are not universal with some migrants losing access to healthcare and benefits.

Estimates suggest that between 54% (La Parra and Angel Mateo, 2008) and 75% (Stevens, 2006) of British people living in Spain are not registered. The main factors that influence the registration of British migrants are taxation rates (on income and property), healthcare costs and social security entitlements (Warnes, 2002). Financial resources may even prevent some people from registering, as there is a minimum income requirement to become a resident (set out in Directive 90/364 Article 1[1]), which may be set above the monetary resources available to some older British migrants living in Spain, particularly those who are largely reliant on only British state provided pensions.

In addition to getting a residency card, migrants must register with their local Town Hall (register on the Padron). This means that they must inform the local council that they live in Spain, which is a legal requirement. This is so that the council can receive their budget from central government in order to plan and carry out services e.g. healthcare and Social Services, rubbish collection, as services are based on a per capita figure. O'Reilly (2004) found that most migrants are not aware of this procedure or confuse it with residency. As such, she found that almost a third of British migrants in the Costa del Sol are not registered on the Padron and half do not have residency cards. Spanish reports also show that only 54% of those registered on the Padron have a residency card (Ministerio del Interior, 2006 in La Parra and Angel Mateo, 2008). The end result of

migrants not registering on the Padron is an under-funding of services in areas where there are large numbers of migrants. This can have a significant negative impact on vulnerable, older British people in need of care, as it can result in the insufficient provision of Social Services in their local area.

### **3.4 Returning to the UK**

This thesis has so far examined the nature of support available to older British people in Spain. This includes informal support from family, friends etc., as well as more formal healthcare, social care and welfare support. Following a decline in health or other crisis which results in extreme vulnerability, an older British migrant may return to the UK in order to access the support that they need (Age Concern, 2007; Hardill *et al.*, 2005).

Evidence suggests that care features prominently in the reason for a return move and the main reason older British people return from EU destinations is to use the national health and social care systems of their home country (Dwyer, 2000; Warnes *et al.*, 1999). Some people make the positive decision to return as they feel it is the right option to them following a change in their circumstances and as Ackers and Dwyer (2002) note, a return move for care may feature highly in the retirement ‘plan’ for older people living abroad. However, they also found that for others, returning was not a plan as such and presented itself as the result of a crisis. Age Concern (2007) also found that some older British migrants may be forced to return to the UK when they can no longer live independently and there are no support systems (most frequently care) in the host country.

There are two key reasons for returning; to be nearer to family, especially children, or to access institutional/state funded care (Ackers and Dwyer, 2002). Those who return to access publically funded care may do so if they do not have children, or because they do not wish to be a burden on their family. Alternatively, some moves are made to provide rather than to receive care. This may be either a return move to support children or care

for grandchildren, or alternatively a move made by adult children (who may themselves be retired) to support their elderly parents (Ackers and Dwyer, 2002).

Making a return move to the UK following residency in another country is not always straightforward. Residency restrictions, as well as the emotional and physical impacts of returning, can result in significant challenges. There is some assistance for vulnerable or ‘distressed’ British nationals from organisations such as Age Concern, the British Consulate and the Heathrow Travel Care Repatriation Project (described in *Fig. 3.2*). These organisations have recognised the difficulties that older migrants can encounter when they return to the UK.

***Fig. 3.2 – Heathrow Travel Care***

Based at Heathrow Airport, the Heathrow Travel Care Repatriation Project employs an independent social worker to provide assistance to returning British nationals with social care needs. Funded by the Foreign and Commonwealth Office (FCO), they work in collaboration with UK and overseas consular staff, as well organisations such as Age Concern España, to assist in the repatriation of distressed British Nationals. Between July 2006 and May 2007, Heathrow Travel Care dealt with 111 repatriations of British Nationals to the UK, with the most common group being those over the age of 50 returning from a European destination.

*Source: Adapted from Age Concern (2007)*

For those who have retained UK residency i.e. never became legally resident in Spain, returning to the UK is not restricted by any legal barriers (as legally they never left). However, for those who were legally resident in Spain, accessing immediate support upon return to the UK can be difficult due to complex UK residency restrictions. Returning British migrants may think that the UK has a plethora of welfare agencies waiting to offer support when they return because they are British nationals who have paid into the system (Age Concern, 2007). However, in reality, if a British national decides to return to the UK permanently after taking up residency abroad, they may not

be automatically eligible for any support. A clarification of Section 54 of the Nationality, Immigration and Asylum Act 2002, issued by the Department of Health states “councils are advised that European Economic Area adult nationals who work in the UK or used to work in the UK and have the right to reside in the UK, should be able to access community care and other social services on the same basis as UK nationals” (Hardill *et al.*, 2005:8). However, this is often not the case as the following demonstrates.

In order to claim income-related benefits (Housing Support, Council Tax Benefit, Pension Credit, Income-based Job Seekers Allowance), an individual must have both a right to reside and be ‘habitually resident’. Whilst returning British citizens automatically have the right to reside, to be classed as ‘habitually resident’ they must pass the Habitual Residence Test (HRT) (Fitzpatrick and Seddon, 2007). The HRT was introduced in August 1994 and only those who can demonstrate that they have a settled intention to stay can pass it. The criteria for the HRT are unclear as “habitual residence is not defined in law and each case will be considered on its merits” (Department for Work and Pensions, 2006b:8). Broadly speaking, one is deemed to be habitually resident if one can demonstrate the intention of making a home in the UK as shown for example by bringing possessions and having ties with the UK. Depending on individual circumstances, passing the HRT can take from as little as a few days to three months. Upon passing the HRT, applications for benefits can take an additional two to three weeks (Age Concern, 2007).

A local authority only has a duty to provide an assessment of housing need under the Housing Act 1996. To be eligible for housing support, a person must pass the HRT, be homeless, in priority need of accommodation, not be intentionally homeless, and have a local connection to the area to which they have applied for assistance (Anaman, 2007a). If a person fails at any of these stages they will not be eligible for housing support.

In order to access support from Social Services, claimants must be living in the UK. A local authority has no duty of care until someone presents to them in person, meaning that applying for services in advance of repatriation can be difficult (Age Concern, 2007). As

with accessing housing support, local authorities do not have a duty to provide a service, only to undertake an assessment of need (under Section 47 of the NHS and Community Care Act (1990)). To meet the eligibility criteria for assistance, claimants need to be, “in substantial need or at risk of becoming critical need” (Anaman, 2007a:4). Critical and substantial need have been defined under the “Fair Access to Care” Policy (DoH, 2003) as someone who needs 24 hour support, is at risk of harm or has been abused, and has no-one else to help them. As such, the criteria to receive help from Social Services are not age-related, so even a frail and vulnerable elderly person may not be entitled to any help. Long waiting lists for Social Services assistance also means that local authorities may be reluctant to take on those who live elsewhere.

Although emergency healthcare is available upon arrival in the UK, if a person needs ongoing treatment they must prove they are ‘ordinarily resident’ before being exempt from hospital charges for ongoing treatment. ‘Ordinary Residence’ is defined as someone who is living lawfully in the United Kingdom voluntarily and for settled purposes as part of the regular order of their life and has a sufficient degree of continuity to be properly described as settled (DoH, 2004). Therefore, those not ordinarily resident will have to pay for services once they are admitted as an in-patient, including following emergency operations and admittance to High Dependency Units (even if this follows from free emergency treatment) or registered at an outpatient clinic (Department of Health, 2004). The current suggestion from the Department of Health (DoH) is that a returnee must show evidence of an address in the UK, e.g. through a utility bill, for six months until they can have free access to ongoing healthcare.

Returning to the UK can therefore be a lengthy and costly (financially and emotionally) experience. However, this is something that people do not realise and instead expect to be able to gain instant access to UK support services (Age Concern, 2007). Furthermore, people may not consider that if they have been living outside of the UK for a considerable period of time, there may have been changes to the health system and services they expect to receive, as well as the possible difficulties of re-integrating (Age Concern, 2007). This may indicate a need for additional information and support for

older British people who are thinking of returning to the UK, as well as ensuring people are fully informed of their rights before taking up residency in Spain.

### **3.5 Main Areas of Vulnerability Facing Older British People in Spain**

There has been a growing realisation in recent years that there are increasing numbers of older British people who are experiencing severe hardship and distress in Spain (Mullen, 1993; Hardill *et al.*, 2005; Age Concern, 2007) and the media have published reports showing expatriates facing problems (BBC, 2006; ITV, 2007). Some of these problems have been discussed in this chapter and are related to rights and entitlements when migrating within the EU, in particular the entitlement to and availability of health and social care services, as well as welfare benefits. On the other hand, another significant problem may arise with the availability of informal support and as discussed in the previous chapter, distance from family and friends in the UK may significantly hinder care and support during old age.

This thesis is concerned with the challenges facing older, vulnerable British people in Spain, and the nature of support available to and utilised by them. The following two sections therefore complete the literature review by summarising the main challenges or vulnerabilities that older British people in Spain face. It examines the policy implications, as well as the social implications of retiring in Spain, thereby drawing together the literature reviewed in this and the previous chapter. It ends with an overview of some support services available to older British people in Spain, including Age Concern España. The following discussion focuses on the three key areas of health and social care, financial/bureaucracy and social support/isolation. These have been previously identified as the most significant problems being faced by older British people in Spain (e.g. Age Concern, 2007; Age Concern *et al.*, 1992) and have also been shown as the main areas of vulnerability facing all older people (Grundy, 2006; Gabriel and Bowling, 2004). They are therefore difficulties that are likely to arise for all older



people, so may not be unique to living abroad; however, they may be compounded by this due to access to formal and informal support, language and cultural barriers, and the transferability of rights.

Health can be the most significant factor in predicting vulnerability. Health problems are most likely to occur in old age, bringing with them frailty and reduced mobility (DoH, 2001). This can be further complicated when living in Spain, where foreign health and social care systems must be negotiated. As discussed in Section 3.1.2, not all retired migrants are entitled to free healthcare and therefore alternative and often expensive options must be sought from the private sector. For those who have the right to use the Spanish health system, the level of care provided may be culturally different to that provided in the UK. This can be especially the case with social care, as although every registered person living in Spain can access Social Services, there are significantly fewer community services and nursing/residential homes than in the UK (King *et al.*, 2000). Although there are a growing number of private nursing services and residential options, these can be very costly and cultural barriers can be restrictive. Older British migrants can therefore face severe problems unless they have the income to purchase nursing or other professional care (Williams *et al.*, 1997). These difficulties are further compounded by language barriers.

Financial and bureaucracy problems are also common among retired British migrants, and these are often related to the need for health and social care, particularly for those with serious or long-term illnesses who need to purchase care. Financial problems may also arise from increased living costs or changes in the economy, such as fluctuations in the exchange rate and therefore the value of the British state pension (Toorney, 2009). Some UK benefits are also stopped when someone spends more than 26 weeks out of the UK, meaning that the income of British migrants may decline when they move abroad. Bureaucracy in Spain can also cause a number of difficulties for migrants, particularly for those who cannot speak Spanish. Becoming a legal resident can be difficult and time-consuming, especially due to the legal paperwork associated with the process. O'Reilly (2004) however found that people who are not registered, not paying taxes and are not

registered with a doctor are the most likely to go home when things go wrong. She also found that even for those who do things properly there is some confusion over registering with the Town Hall, changing car license plates, paying rates, voting, entitlements to healthcare and registering with the local health services. There may therefore be a lack of information and advice for migrants on local bureaucracy.

On the other hand, as discussed in Chapter Two, generating sufficient social support when living abroad, especially when faced with a crisis, can cause or compound vulnerability. Social isolation and loneliness may be common among older British people in Spain. Social isolation occurs when someone has a lack of meaningful relationships and social integration (van Baarsen *et al.*, 2001). This can occur during the initial process of settling in Spain as people may find themselves in a country they do not know, without friends or family nearby. Making new friends can be difficult in later life, especially making good friends, and O'Reilly (2000a) found that people make many acquaintances but no real friends when they move abroad. Boredom and apathy are not uncommon for those with a lot of time on their hands following retirement, which for some results in alcoholism and marital problems (Mullen, 1993; Huber and O'Reilly, 2004).

Language barriers can contribute to social isolation, as limited contact with the Spanish community can leave people feeling "marooned in the faceless urbanisations" (Mullen, 1993:1015). Cultural differences may not have been anticipated, as living and holidaying abroad can be very different, which may lead to cultural alienation and resentment between nationalities. Bereavement has been noted as the greatest difficulty that expatriates have to face (Mullen, 1993) and problems become compounded once a person becomes ill or frail and is in need of additional support. Emotional isolation can also occur with the absence of an attachment figure (van Baarsen *et al.*, 2001) and is high for those without a partner or who are widowed. Although bereavement can be the greatest problem facing older couples, few give it serious consideration but results can be a reduced income and greater isolation, often forcing a return move to the UK (Harbert,

1994). Women are often more vulnerable following bereavement when they are dependent on their partners for transport and practical support (Mullen, 1993).

Another concern can be physical isolation which may come from the choice of property and its location. Some villas and apartments have many steps, or are built on a steep hill located far away from services and shops, making it essential to own a car (Mullen, 1993) (illustrated in *Fig. 3.3*). However, when someone is no longer able to drive due to declining health, living in an area with few facilities and a lack of public transport can increase isolation. This can also be the case in the UK, however cultural and language barriers can compound isolation in Spain. Furthermore, some coastal areas which are a hive of activity during the summer months can become like ghost towns out of season, as many properties are holiday homes or used during the summer trade (Harbert, 1994).

***Fig. 3.3 – Isolated Residence in Spain***



Source: Author's own

Therefore, having access to a car or another type of transport can reduce the vulnerability faced by older people, especially with regards to social isolation. Those with transport can participate in social activities not confined to the home and gives people the ability to visit friends and relatives. Car ownership is a symbol of independence and autonomy and quality of life is often reduced when private transportation is lost (Davey, 2007; Gilhooly

*et al.*, 2003). Whilst good and cheap (or free) public transport can improve older people's quality of life (Gabriel and Bowling, 2004), it can be limited by inadequate information on availability, inappropriate operating practices, lack of help from staff or insufficient security (Department for Transport, 2001). Taxis are another option but can be very expensive so only available to those with sufficient financial resources (Department for Transport, 2001). The availability of transport for older British people in Spain has been found to be limited, especially in rural areas (Hardill, *et al.*, 2005). This may be compounded by language barriers, especially for the most vulnerable groups. There is currently very little research on the use of transport among older British people in Spain, so this thesis will examine the use of both private and public transportation and the impact this has on social networks, isolation and vulnerability.

Other problems facing expatriates are related to the local environment, including high noise levels, insecurity and dirtiness, often related to overcrowding, mass tourism and mass urbanisation (Rodriguez *et al.*, 1998). This can be seen in the numerous urbanisations in Spain, which are vulnerable to criminals and easy targets for crimes such as burglary and theft (Gaskin, 2007). In addition, although the most common reason for moving to Spain is for the warm weather, an oppressively hot and humid climate may be a distinct disadvantage for some (Rodriguez *et al.*, 1998). Alternatively, winter months in Spain can be cold and this is not anticipated by people before moving who are not properly prepared e.g. by having sufficient heating (Holbrook, 2004).

All of the above problems cannot be taken in isolation from each other. For example, if someone experiences a health problem, insufficient social care may mean they need to pay for private nursing care, which leaves them with limited finances. They may then become isolated from their friends and potential sources of support when their mobility declines. These problems can be compounded by not being able to speak Spanish, as they will be unable to communicate with local services and potential sources of support. The language, culture and other barriers that make integration and settlement abroad challenging may be exacerbated by a lack of preparation by British migrants before they move abroad (Sriskandarajah and Drew, 2006). People may have false expectations due

to insufficient planning, and this gap between expectations and reality may make it more difficult to solve problems. Some do not anticipate the cultural differences between the UK and host country, from the siesta times, to health and social care availability. A lack of information has been found to exacerbate these difficulties and suggestions have been made for the availability of more accurate and appropriate information (Age Concern, 2007). The result is that vulnerability, frailty and loneliness may be more common among older British people living in Spain, than those living in the UK.

At the present time, the British government does not accept that it has a responsibility to provide care for its citizens who are resident outside of the EU, and there is no immediate prospect of a change in this policy (Hardill *et al.*, 2005). Furthermore, some members of the British community in Spain fall through a support gap, whereby they are no longer the responsibility of UK welfare services, yet not fully recognised in their new country of residence. Sriskandarajah and Drew (2006) also found that British people living overseas feel that more should be done to support them, especially those on a limited or fixed income:

Across all British emigrants, there is the strong view that the government should engage more directly with its citizens overseas. Many felt that once they had left Britain's shores they became invisible...in the eyes of the government of the country they had come from (Sriskandarajah and Drew, 2006:64).

This has led to UK based institutions, such as charities, playing an important role in the provision of support, especially at times of crisis. A large number of people are turning to British charities in Spain such as Age Concern España for support and assistance, particularly with interpreting and aftercare (Stevens, 2006; Hardill *et al.*, 2005). The following section identifies some of the support services available to older British people living in Spain, including charities and government support. It ends by discussing Age Concern España, which provides an example of the crucial role voluntary organisations can play in supporting older British people in Spain.

### **3.6 Support Services for Older British People in Spain**

In addition to informal support from friends and family, and the formal health, care and welfare services discussed in this chapter, there are some other sources of support for British older migrants. The first place many people turn when in trouble abroad is the British Consulate (Sriskandarajah and Drew, 2006), who offer support and advice to all British people, from getting a new passport to providing help if someone is in hospital. They do also in exceptional circumstances offer a higher level of support, including providing financial assistance (which must be repaid) and organising repatriation to the UK. They also offer advice for people thinking of moving abroad, and have produced publications and checklists for those who intend to move abroad. Their ‘Know Before You Go’ awareness campaign is also aimed at encouraging British travellers to be well prepared before going overseas (FCO, 2009). The British Consulate in Spain frequently work with Age Concern España to help older British people living in Spain who are experiencing difficulties, including with repatriation and the organisation of care and financial support. Age Concern also runs an Information Line, based at the British Consulate in Palma, Mallorca. This is a collaborative project between Age Concern and the Consulate, which provides information and advice to older British people across Spain. The Information Line began in Mallorca in 2006 and now has national coverage.

For those in need of information and advice regarding pensions and benefits, there is the above mentioned support and liaison team funded by the Department of Work and Pensions (DWP) based at the British Consulates in Alicante and Malaga. They are able to provide information for expatriates on pensions and benefits, as well as on registering for healthcare (FCO, 2007). They have worked in conjunction with Age Concern España, including holding open days with local Age Concern organisations in Mallorca. Some Spanish local authorities have also responded to the needs of migrants, by opening Foreigners’ Departments in some areas, such as Mijas and Estepona. Multilingual staff are employed to provide foreigners with information and help on local bureaucracy and interpreting. However, they do not offer financial support, or any form of health and social care (Estepona Foreign Residents Department, 2007).

There are therefore some government funded support systems in place for older British people in Spain, however British-run charities and voluntary services in Spain also provide a large amount of help to British people in need. These complement and often supplement the health and welfare services offered by the Spanish Social Security System. For example, the Royal British Legion in the provinces of Malaga, Alicante and Valencia have well developed voluntary welfare services (Betty and Cahill, 1999). There are also a range of other British charities linked to HM Forces or occupations, such as the Royal Air Force or Royal Marines Benevolent Funds which can provide subsidies and grants to British people living abroad.

Another source of support for older British people in Spain is the British run charity 'Help'. 'Help' has a number of branches across the Costa Blanca area, which provide information and advice, transport, social support, equipment hire, and hospital visiting teams set up to provide interpreting and support for patients (Help, 2008). Another organisation is 'Cudeca'; a charity in the Costa del Sol founded by a British lady providing free of charge Palliative Care for those suffering from terminal cancer, and offers out-patient care and support for patients and their carers/family. They also have a hospice day centre and in-patient unit with fifteen beds (Fundacion Cudeca, 2009). The older British community are also involved with the Spanish Red Cross who have developed a tele-alarm service with English speaking operators, as well as the Asociación Española Contra el Cancer (AECC) which is a Spanish national cancer charity with branches across Spain. Some branches of AECC have British committee members who liaise with the English speaking community, arrange screening and support cancer patients and their families. One branch in the Costa Blanca has raised sufficient funds to provide beds for terminally ill cancer patients (Tasker, 2007).

### ***3.6.1 Age Concern España***

The research for this thesis was undertaken in collaboration with Age Concern España. Age Concern España<sup>8</sup> is a national federation established in 1994 that provides specialist information and advice for British people over the age of fifty in Spain. It currently has five local organisations; Costa Blanca Sur, Estepona y Manilva (Costa del Sol), Ibiza, Menorca and Majorca, as well as a national information line based in Mallorca (see *Fig. 3.4*). Each organisation relies almost entirely on the unpaid work of members of the English-speaking community and on voluntary donations, including grants from its main funders: Age Concern England, the Royal Air Force Benevolent Fund and SSAFA Forces Help. Each Age Concern has been established in response to a local need, and so each has a slightly different organisational structure and offers services geared to the needs of the British community, including the provision of information and advice, home and hospital visiting, equipment loans, transportation, interpreting services and social activities. Some organisations have their own charity shops and social centres, whilst others are run from the homes of volunteers (see *Fig. 3.5*).

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<sup>8</sup> See [www.acespana.org](http://www.acespana.org)



*Fig. 3.4 - Map of Spain Showing Location of Each Age Concern España Organisation*



Map Source: [www.lonelyplanet.com/mapshells/europe/spain/spain.htm](http://www.lonelyplanet.com/mapshells/europe/spain/spain.htm)

*Age Concern Costa Blanca Sur* is located in Torrevieja and is the largest organisation with over 100 volunteers. It has its own charity shop and a centre which functions as an information and advice centre, a meeting place/social environment, and location for the sale of books and monthly fêtes.

*Age Concern Mallorca* has approximately 20 volunteers and has no centre or shop and therefore no definable base. It is run from the homes of volunteers. *The Age Concern Federation* is also located in Mallorca, and focuses on dealing with complex and long-term cases, and co-ordinates between each of the organisations. A national *Age Concern España Information Line* opened in 2006 based at the British Consulate in Palma, Mallorca, which provides an information and advice line for older British people in Spain.

*Age Concern Estepona y Manilva* is located in the Costa del Sol and has approximately 50 volunteers. It has a shop to where enquiries are directed and which provides a base for the organisation.

*Age Concern Menorca* is a small organisation with around 30 volunteers mainly working from their homes. It does have its own shop which provides a base for the organisation.

*Age Concern Ibiza* is a very small organisation with fewer than 10 volunteers who work from their own homes.

**Fig. 3.5 – Key Information on Each Age Concern España Organisation**

<b>Age Concern Organisation</b>	<b>Approx. number of volunteers</b>	<b>Shop?</b>	<b>Centre?</b>
<i>Costa Blanca Sur</i>	100	Yes	Yes
<i>Mallorca</i>	20	No	No
<i>Menorca</i>	30	Yes	No
<i>Estepona</i>	50	Yes	No
<i>Ibiza</i>	10	No	No

Research by Hardill *et al.* (2005) examined the nature of enquiries received by Age Concern España and found most enquiries to be related to issues around health and social care. This research indicated that Age Concern España receives around 12,000 enquiries a year, with one in eight notifying a ‘serious need’ for additional income or support, thereby highlighting a high level of need within the older British community in Spain. This thesis expands on the research of Hardill *et al.* by undertaking an in-depth analysis of the enquiries received by Age Concern España. This has enabled a more comprehensive understanding of the challenges and vulnerabilities faced by older British people in Spain.

### 3.7 Summary

This chapter has focused on the availability of healthcare, social care and welfare services in Spain, as well as the rights of older British people to access these services. The healthcare rights of some older British migrants resident in Spain are compromised by the tiering of entitlement that exists in relation to EU citizenship rights; ultimately this means that many British early retirees who are resident in Spain, but who have never undertaken paid work there, have little or no access to publically provided healthcare. Whilst social care is available to all Spanish residents, state-funded care services may be limited due to an expectation of family care in Spain. The only option may be private care which can be very expensive. Financial support is however also very restricted, with limited welfare benefits being available in Spain or exportable from the UK. In addition, language and cultural barriers can further reduce access to support services. This can lead to increased vulnerability, as people have limited resources available to them to cope with the challenges that they face.

Some have argued that the older British community in Spain is inadequately supported by state services (Holloway, 2005) and as a result they are turning to the voluntary sector for help. This includes Age Concern España who frequently help those in need of additional support, especially care or financial support (Hardill *et al.*, 2005). Alternatively, for some older British people in Spain a return move to the UK becomes necessary; however this can be a complex process with UK residency restrictions impeding access to support upon return.

The following chapter outlines the research methodology, including a discussion of the research aims, methods, research participants and interpretation of the findings. It also highlights the role of Age Concern in the research process.

# **Chapter 4 - Research Design and Methodology**

This chapter sets out the research methods employed and how they were used to meet the project aims. It engages with the conceptual issues central to the qualitative approach used to explore the narratives of ageing abroad within a case study design. The research was developed in collaboration with Age Concern, and therefore the chapter begins by outlining the role of Age Concern as the CASE partner. It then moves on to discuss the research methods and approach employed. The research was undertaken in two main stages; (1) a survey of enquiries to Age Concern España; and (2) in-depth interviews with Age Concern users. The design and implementation of these stages is addressed in this chapter, as well as a discussion of the ethnographic observations used to develop the research methods and to collect contextual data. The chapter then discusses the case study approach, followed by the data analysis processes. The chapter ends with an overview of any ethical issues and my own reflections on the research process.

## **4.1 Background**

My PhD was funded as part of a CASE studentship by the ESRC and Age Concern. The research was scoped in the first instance by Age Concern and my supervisors. I then developed the research aims and methods following a review of existing literature on the topic, as well as through conversations with and observations of Age Concern and its users. Whilst I led the research, Age Concern were engaged in the entire research process, through defining the research agenda to disseminating the findings. I also worked interactively with Age Concern España during data collection, and they helped shape the survey design and implementation. Collaborating with Age Concern has resulted in co-produced knowledge (Hardill and Baines, 2009), as well as knowledge

transfer (ESRC, 2009). In doing so, the research has been used to promote the needs of older British people in Spain through Government policy at a local and national level, as well as through practical benefits by improving the efficiency, effectiveness and quality of Age Concern services in Spain. This has been achieved through two outputs for Age Concern; a service development report and a policy report.

There were a number of other benefits to working with Age Concern. This included obtaining access to an otherwise hard-to-reach population. I was also able to draw on the experience and expertise of Age Concern España volunteers, who were themselves older British people living in Spain. This provided me vital insights into my research participants. Age Concern España volunteers are key stakeholders in the research and it was therefore important to involve them in a participatory way. Some theorists have argued that research on older people should only be done by older people (Biggs, 2005); however, this could introduce a significant bias as for example many Age Concern volunteers may themselves be vulnerable and experiencing similar difficulties to the research participants. Therefore, as a 27-year-old ‘outsider’, I was able to engage with the issues and difficulties facing older people in Spain in a more objective manner.

The research therefore had multiple aims, which were necessary in order to meet the requirements of the PhD as well as the needs of Age Concern. To achieve these aims, a mixed-methods approach was taken by combining qualitative and quantitative methods; a survey of enquiries to Age Concern and in-depth interviews. The research does however have a qualitative focus.

## **4.2 Research Aims and Questions**

The primary focus of the research was to explore the experiences of vulnerable, older British people in Spain, looking at the main challenges they face and the nature of

support available to and utilised by them. This thesis has seven research questions (see *Fig. 4.1*), which addressed the following three aims.

### Aim 1

*To examine the lived experiences of vulnerable, older British people in Spain focusing on the difficulties and crises they face as a result of changing life circumstances with ageing.*

This aim was first addressed through the survey of enquiries to Age Concern (detailed in Section 4.6). Through the survey, it was possible to ascertain the main difficulties faced by Age Concern España users. Whilst it is recognised that this sample may not be representative of vulnerable, older British people in Spain, it did give an indication of the main areas of vulnerability of this population through examining the most commonly cited difficulties. These were then identified and explored further through in-depth interviews.

### Aim 2

*To examine the kinds of support networks that vulnerable, older British migrants construct and access in the UK and Spain (e.g. family network, friendship network, voluntary sector) and the role that they play during times of crisis.*

This aim was answered through the in-depth interviews, which examined the social and support networks of participants. Interviews addressed the support received from friends, family and neighbours, as well as the voluntary and community sectors. As the research was a collaborative study with Age Concern, all interviewees had received some support from Age Concern España and the nature of this support was examined. The interviews also addressed the location of networks and as such the extent to which participants were transnational.

### Aim 3

*To examine the impact of UK, EU and Spanish policy on the rights of vulnerable, older British people living in Spain to access healthcare, social care and social security.*

This aim was explored through the in-depth interviews, which asked participants about the nature of statutory support available to them from the UK and Spanish governments. This focused on health and social care provision, as well as financial support.

The following research questions were constructed in order to meet these research aims.

#### ***Fig. 4.1 – Research Questions***

1. What are the most significant difficulties or crises facing older British people living in Spain which contribute to them becoming vulnerable?
2. What formal and informal social and support networks do older British people in Spain construct and access, and what role do they play in response to difficulties or crises?
3. Where are the social networks of vulnerable, older people living in Spain located and to what extent are individuals transnational?
4. To what extent can and do vulnerable, older British people in Spain access healthcare, social care and welfare services in Spain and the UK (or elsewhere)?
5. Do older British people in Spain return to the UK when they encounter a crisis in Spain and what are the experiences of those who decide to return?
6. To what extent do British voluntary services in Spain, such as Age Concern España, support vulnerable, older British people living in Spain?
7. To what extent does UK, EU and Spanish policy recognise the needs of vulnerable, older British people living in Spain?

### **4.3 The Role of Age Concern**

As mentioned in Section 4.1, the research was first scoped and then co-produced with Age Concern England and Age Concern España. This section provides some background on Age Concern and the context within which the research took place.

#### ***4.3.1 Age Concern England***

The research was part-funded by Age Concern England through their European and International Unit as part of their “Older People Residing Abroad Programme”. This Unit has strong connections to international organisations, including overseas Age Concern organisations, and works to influence UK, European and International policy with regards to older British people living abroad. They work very closely with Age Concern España and encourage collaborative working with other local and international organisations. Programme Officers from the Unit helped to supervise the project and were highly involved in developing the research, especially in defining the research questions. This was done in the initial stage of the research in collaboration with my supervisors and before I began the PhD. Age Concern England were particularly interested in understanding the level and nature of need among older British people in Spain, and wanted to take forward the research findings to influence policy. As a UK based organisation, they had little involvement in the fieldwork, however, regular communication and UK based meetings took place at key stages in the research allowing them to collaborate throughout the research process.

#### ***4.3.2 Age Concern España***

Whilst Age Concern España (for details of the organisation see Section 3.6.1) were not directly funding the research, they provided access to and substantial use of their resources and volunteers during fieldwork periods. They fully supported the research as



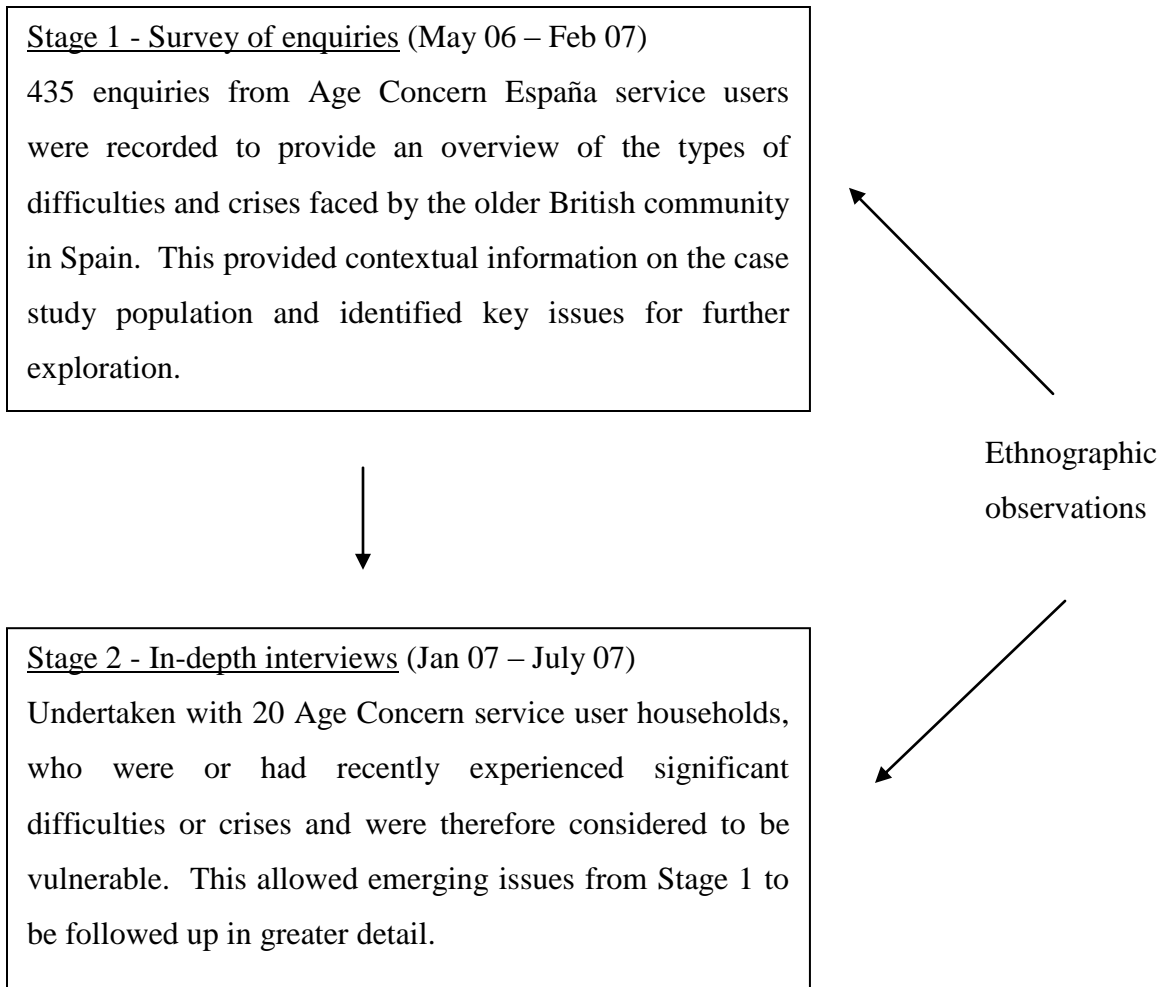
their work with Age Concern England had led them to look at the enquiries they received in more depth. This led to an initial pilot research project by Hardill *et al.* (2005) (see Section 1.1.2 for further details), which was co-authored by Age Concern England and Age Concern España and subsequently led to this CASE studentship. Hardill *et al.*'s research was primarily an interview-based study with selected vulnerable, older British people in Spain. Whilst it refers to data on the number and type of enquiries received by Age Concern España, these are largely based on estimates and no wide-scale survey was undertaken. This research led Age Concern España to review their services; however, they required more detailed data on the nature of difficulties faced by their service users. This PhD was therefore developed with this aim in mind, and as such includes a comprehensive survey of enquiries to Age Concern España conducted across two different points in time and includes all Age Concern España organisations. This survey builds on the pilot undertaken by Hardill *et al.* and is being used to identify the needs of service users and for service development purposes. Age Concern España were therefore involved in the design and implementation of stage one, the recording of enquiries, and have used the findings to develop the services they offer.

## **4.4 The Research Process**

### ***4.4.1 The Research Design***

In order to explore the research aims and questions, the research design consists of two key stages; a survey of enquiries to Age Concern España and in-depth interviews. In addition, ethnographic observations were used to both inform the research design and to collect contextual data. Whilst the observations were used throughout the data collection period, they were mainly used to inform the interviews so were not classed as a separate research stage. The research includes qualitative and quantitative data; however, it does have a distinct qualitative focus, with this thesis largely using the in-depth interviews to elicit the individual experiences of older British people in Spain. The research design is outlined in *Fig. 4.2* and each method is discussed in depth in Sections 4.6, 4.7 and 4.8.

***Fig. 4.2 – The Research Design***



#### ***4.4.2 Selecting Research Participants – Recruitment Criteria***

All research participants were recruited through Age Concern España. It is recognised that there is some selection bias in the research sample in that it included only those who have been in contact with Age Concern España. It is likely that this group have more support than non-Age Concern España users, as it is evident that they have used the services of at least one voluntary organisation in Spain. However, vulnerable, older British people in Spain are a hard-to-reach population, especially those who have

accessed no support networks, and therefore Age Concern España were able to provide access to a sample of these people; people who otherwise might have remained hidden.

On selecting a sample of vulnerable, older British people in Spain a number of difficulties arose with defining the boundaries of this population. This was firstly due to the population of retired migrants being highly transient (discussed in Section 1.1), with many spending time in both Spain and the UK. As a result, only interviewees who had lived in Spain for at least six months of the year were included. However, finding out how long someone spends in Spain also proved difficult because as O'Reilly (2000a) has previously found, discussing place of residence can be difficult as some migrants live illegally in either the UK or Spain. Whilst participants were asked how many months they spend in Spain, it is recognised that this may not always be accurate.

The second difficulty was with the categorisation of old age. The definition of “older people” is highly debated, as the transition between “young” and “old” is quite fluid and complex (Meadows, 2004). This thesis draws upon guidelines from the National Service Framework for Older People (2007a; 2001) and Age Concern (2009), which both define older people as being over the age of 50. As a result, only British people over the age of 50 were asked to take part in the interviews. In addition, only those who were considered vulnerable were invited to take part (see paragraph below). Stage one did include some younger enquirers because Age Concern as a charity do not exclude the under 50s from receiving help and advice, however, these were filtered out before the analysis of the data. Equally, there were some non-British enquirers as again it was not Age Concern policy to exclude these people but again they were filtered out before analysis.

The final consideration came with selecting those who were considered to be vulnerable. The definition of vulnerability by Schroder and Gefenas (2009:117) - “to be vulnerable means to face a significant probability of incurring an identifiable harm, while substantially lacking ability and/or means to protect oneself” - was taken into account when selecting participants, as well as Hardill *et al.*'s (2005) criteria of those in critical situations. Hardill *et al.* note that those in critical situations have often experienced a

radical decline in quality of life due to a decline in health or lack of finance and require additional income or support. Therefore, interview participants were selected who currently were or recently had encountered a significant difficulty, and appeared to be in need of additional support, either from Age Concern España or elsewhere. Such people were identified through the survey of enquiries or through Age Concern volunteers (discussed further in Section 4.4.3). Therefore, the final recruitment criteria for the interviews was “vulnerable, British people over the age of 50 who spend at least six months of the year in Spain and have used the services of Age Concern España”.

#### ***4.4.3 Sampling Strategies***

There are well documented barriers to the recruitment of older adults in research, mainly due to health problems and social difficulties (DiBarolo and McCrone, 2003) which can limit a person’s ability to take part. Health problems such as deafness can restrict participation in research and social exclusion can leave older adults unwilling to participate in outside activities, which includes research. Older British people living in Spain are even more difficult to recruit as they may not register in Spain, so many are not easily identifiable from official records. As a result, recruiting a representative sample which accurately represented the population from which it was taken (Saunders *et al.*, 2007) was not possible. Therefore, a non-random sample was adopted; an approach widely used in qualitative research where the purpose of the data is not to generalise to a wider population but instead to infer to theory (Williams, 2002). The key aim was to maximise participant variability to incorporate a range of experiences, characteristics and examples.

The research participants were all accessed through Age Concern España. This overcame the difficulties in recruiting retired migrants due to their “hidden” nature (O’Reilly, 2000a) and “transient” tendencies (Lozanski and Beres, 2007). Age Concern acted as gatekeepers and allowed me access to all of their service users and as such a large potential sample. They also arranged publicity for my research in the local English press

and Age Concern newsletter. By affiliating myself with Age Concern, a respected local organisation, I was able to add legitimacy to the research and make participation more attractive (DiBarolo and McCrone, 2003). Furthermore, the large number of Age Concern service users across five regional organisations meant that it was possible to recruit a diverse sample, including according to area of residence.

Whilst recruiting through Age Concern had clear advantages, it is recognised that this led to some bias in the sample, as those who had not been in contact with Age Concern were excluded. This means that whilst the research design is a case study of older British people in Spain, the case in question does only include Age Concern España service users. In addition, whilst a sample of variability was recruited, this generally only included participants living close to one of the five Age Concern organisations (mainly concentrated around the coast). The survey of enquiries (see Section 4.5) conducted through the information line does, however, cover the whole of Spain and this survey as well as existing data does indicate that the vast majority of older people live in coastal regions. The resulting sample was therefore one of convenience, which was available by virtue of its accessibility and is not representative of a particular population (Bryman, 2004). However, the emphasis of this research is of personal accounts and narratives, rather than on representativeness.

#### ***4.4.4 Securing Access and Collecting Data in Spain***

As the research was examining the lives of British people living in Spain and recruitment was through Age Concern España organisations, the data collection took place in Spain. Whilst this was beneficial in terms of immersing myself in the data and therefore understanding participant experiences, the wide geographical spread of Age Concern España meant that the fieldwork took a considerable time to plan and 19 months to complete. This involved 11 fieldwork visits to Spain (detailed in *Fig. 4.3*), including two initial visits in January and March 2006 to secure access. These initial visits involved observing and liaising with Age Concern España volunteers, the gatekeepers, to develop

relationships and gain access to the organisation for the purpose of the research. Gaining links in Spain was essential to allow access to data and participants not readily available (Nash, 2000). Therefore, gaining the trust of key gatekeepers was essential (Lozanski and Beres, 2007), including the President of Age Concern España as well as the Presidents of the individual organisations. Much of these visits were spent discussing the research with the organisation Presidents, and working with volunteer researchers to ensure co-operation and support from everyone involved in the data collection during stage one. These preliminary visits also allowed me to collect initial data through observations which were used to develop the co-produced research tools. They were also used to familiarise myself with the organisations, volunteers and practices because as Barrett and Cason (1997) note, familiarity with the research site is essential.

The fieldwork was based at the larger Age Concern España organisations in the Costa Blanca, Costa del Sol and Mallorca. Ibiza and Menorca were included in Stage One via telephone and email communication but were not fieldwork sites due to their smaller Age Concern organisation size as most volunteers work from their homes. As Mallorca was included as a fieldwork location, it was considered to be somewhat representative of the Balearic Islands. Two mainland locations were included so as to ensure variability in the sample. Participants differed according to area of residence, especially in terms of social class and wealth, with those in the Costa del Sol appearing to be wealthier.

**Fig. 4.3 – Fieldwork Activities Undertaken**

<b>Date</b>	<b>Location</b>	<b>Fieldwork Activities Undertaken</b>
January 2006	Torre Vieja (Costa Blanca)	Initial visit to Spain to secure access.
March 2006	Mallorca (Balearic Island)	Attend Age Concern España AGM to secure access.
May 2006	Torre Vieja	Piloting of survey of enquiries.
May 2006	Mallorca	Piloting of survey of enquiries.
September 2006	All Spanish locations; I was in Torre Vieja only	Survey of enquiries, Phase 1 (2 week recording period).
January/February 2007	All Spanish locations; I was in Torre Vieja only	Survey of enquiries, Phase 2 (2 week recording period).
January 2007	Torre Vieja	Selecting interview participants, piloting interviews, 1 interview conducted.
February 2007	Estepona	Selecting interview participants, piloting interviews, 2 interviews conducted.
May 2007	Torre Vieja	7 interviews conducted.
May 2007	Mallorca	5 interviews conducted.
July 2007	Estepona	5 interviews conducted.

The fieldwork was planned carefully so as to fit in with the gatekeepers, as it was essential that their resources and volunteers could be utilised. Fieldwork visits were set up according to the availability of each Age Concern organisation, so were rigid and had to be adhered to. The fieldwork was also largely dictated by the ESRC who granted a fixed overseas fieldwork allowance, so costs needed to be carefully planned. The demands of the ESRC and Age Concern therefore meant that fieldwork dates and costs were largely fixed and additional fieldwork visits were not viable. To ensure each of the

three main research sites could be visited at least once during stage one and two, each fieldwork visit was relatively short and lasted between 2-3 weeks. Multiple visits to each location were required in order to set up, pilot and carry out the survey and interview stages. This led to some limitations with the choice of interviewees as only people available during my time in Spain could be included. Whilst every opportunity was taken to arrange interviews in advance from the UK, this was often not feasible leading to some interviewees being excluded. Had the research been conducted in the UK, a more flexible approach could have been taken.

There are noted logistical difficulties in conducting interviews overseas, and Lozanski and Beres (2007) found that whilst it can be easy to meet and recruit participants when overseas due to a shared culture, arranging and maintaining appointments “creates interesting challenges” (2007:7). They found that the lack of stability of a transient population means they often do not know where they will be at any given time and therefore interviews cannot be planned too far in advance. Whilst similar difficulties were encountered in Spain, the sample recruitment target of 20 households was met.

## **4.5 The Survey of Enquiries**

The first stage of the research was a survey of enquiries to Age Concern España, which was undertaken to address the first research question, i.e. to examine the challenges or crises facing older British people in Spain. Research by Hardill *et al.* (2005) suggested that there are a growing number of vulnerable, older British people in Spain in serious need of additional income or support, so this in-depth survey allowed an exploration of the type of challenges encountered and the nature of support. This provided contextual information on the research population and sensitised me to the nature of vulnerability experienced. It therefore shaped the direction of the in-depth interviews and informed my interview sample. This ensured that I did not enter the interviews with a set of preconceptions (Russell, 1999), as it allowed the interviews to be based on empirical findings rather than any pre-conceived ideas. The survey was able to identify households



in need, and by doing so I was able to invite them to take part in an interview, thereby collecting cases for in-depth work. This provided a sampling frame from which in-depth interviewees were selected and ultimately granted me easier access to participants.

This is the first comprehensive survey of enquiries collected directly from older British people in Spain and was used both for the purpose of the thesis and also by Age Concern España. As research collaborators and part-funders, Age Concern España used the survey results to gather information on the type of people using Age Concern España services and to understand the main difficulties they face. This data has been used to target their services more effectively according to the needs of their service users. It was therefore important to recognise that the survey was designed for both this thesis and Age Concern España.

Due to these two distinct aims, the survey was co-designed with Age Concern España. All enquires they received over a 4-week period were recorded on a carefully designed proforma (see Appendix 1). Enquiries were recorded during two two-week periods in Autumn and Winter to represent the different types of enquiries received over the year and because these are the times of year when the majority of older British people are in Spain, as many return to the UK for the summer months (King *et al.*, 2000). In total, 435 people contacted Age Concern España during the recording period and a total of 503 enquiries were recorded as some people enquired about more than one issue.

The survey of enquiries was carried out by the six Age Concern España organisations, including the Information Line/Federation. Whilst I co-ordinated and supported the survey, Age Concern implemented it. It was essential that all organisations recorded the same information at the same time which required the co-ordination of resources and consistency in recording. To ensure this, the proforma was co-produced between myself and Age Concern España. During the preliminary fieldwork visits I observed working practices and undertook informal discussions with volunteers as a way in which to identify ranges of behaviours, attitudes and issues (Hoinville and Jowell, 1985). During this time different versions of the proforma were piloted and changed according to

volunteer/organisational needs and working arrangements, as well as in accordance with the required outcomes of Age Concern. The final proforma was used to record the following information:

- The nature of the enquiry.
- The action taken on the enquiry (by volunteers).
- The type of enquiry i.e. phone, email, face-to-face.
- The date and time of enquiry.
- Additional information on the enquirer (or the person needing the assistance if this is not the enquirer): nationality, gender, age, area of residence, marital status, number of years lived in Spain, number of months per year spent in Spain, previous occupation and involvement with HM Forces (as most of Age Concern's income is from HM Forces charities).
- The proforma included an invitation for enquirers to take part in an interview if selected. This allowed any interesting enquiries to be followed up in more depth.

A full pilot of Stage One was carried out across the five locations and was used as an opportunity to test out the method and thereby increase the likelihood of success in the main study by giving advance warning of where the research could fail (Van Teijlingen and Hundley, 2001). This uncovered some inconsistencies in recording due to the different operating systems and resources available at each organisation. These were addressed through minor changes to the proforma as well as through face-to-face, email and telephone communication between the volunteers and I. I also maintained regular communication with all organisations during recording periods.

## 4.6 The In-Depth Narrative Interviews

### 4.6.1 *The Narrative Approach*

The second stage of the research was qualitative in-depth interviews, which were used to further investigate the needs of older British people in Spain. The interviews adopted the narrative approach which enabled the stories and lived experiences of vulnerable, older British people living in Spain to be heard; stories which encompass both the individual and social as told from the perspective of the individual involved. This approach allows the exploration of the participant's understandings and interpretations. Central to this is getting close to the people under study so we can persuade them to "tell it like it is" (Dingwall and Murphy, 2003:29). By giving voice to participants through the active construction of their stories it is possible to help redress some of the power differentials inherent in research (Elliot, 2005:17). This same approach has been used in the study of chronic illness, and has enabled people to discuss their experience of illness, as well as the impact of illness on their social roles and sense of worth (Gilbert, 2008). One of the most significant difficulties facing vulnerable, older British people in Spain is poor health or chronic illness, so this approach is appropriate. Furthermore, the approach is also linked with feminism which promotes qualitative methods, as they are sensitive to women's experiences and promote empowerment (Henwood and Pidgeon, 1993; Grbich, 2007).

The narrative approach therefore seeks to examine the stories people tell about their experiences, values and relationships. They are that person's interpretation of the social world, as created through an interaction between the researcher and the participant:

Narratives are social products produced by people within the context of specific social, historical and cultural locations. They are related to the experience people have of their lives, but they are not transparent carriers of that experience. Rather, they are interpretive devices through which people represent themselves, both to themselves and others (Lawler, 2002: 242).

Narratives were therefore used to understand the subjective, personal experiences of participants. Plummer (1995) refers to the personal experience narrative as a tale told by a person about the self and these are socially embedded in the daily strategies and practices of everyday life. According to Elliot (2005), narratives have three distinct features each of which were adopted here:

1. Chronological: they are representative of a series of events and as such the interviews took a life history approach, focusing on how people explained and reflected upon their past, present and future (Hardill *et al.*, 2007). The interviews began with the initial move to Spain, followed by life in Spain and the challenges associated with ageing and finally future plans.
2. Meaningful: they understand the underlying meaning of behaviour and experience from the perspective of the individual(s) involved and as such the participants were encouraged to talk about their own experiences and reconstruct key events in their lives.
3. Social: they sought to understand the social context within which certain behaviours took place and were constructed through interactions between the researcher and the interviewee. The interviews were therefore not entirely individual centred, as a life history cannot be told without constant reference to social and cultural context, historical change and institutional structures (Musson, 1998 in Hardill *et al.*, 2007). The life story approach gives the opportunity to explore the relation between personal and collective experience (Rogers and Leydesdorff, 1999) and the impact that social, cultural and political structures have on these experiences.

Interviews were therefore used to generate narrative accounts of the experiences of and challenges facing older British people in Spain. The interviews were an interactive process built around gaining an insider view, which was done through building and maintaining a reciprocal relationship between myself and participants (Grbich, 2007).

The interview became a social interaction, where I as the interviewer attempted to recognise and understand the interviewee's experience (Bondi, 2003).

#### ***4.6.2 Conducting the Interviews***

The focus of the interviews was therefore on individual life stories, beginning with reasons for moving to Spain, what had happened since, how social networks were developed and maintained since living in Spain, how networks were mobilised in response to challenges and finally future plans. Interviews were used to further understand the lived experiences of older British migrants as ageing individuals and members of a community and were used to answer all of the research questions in-depth.

Interviewees were chosen who were considered to be vulnerable or in “serious need of additional income or support” (as used by Hardill *et al.*, 2005:774) due to a significant crisis or challenge they had encountered. Findings from the survey of enquiries indicated that health/care, finance and social crises were the most common causes of serious need and vulnerability (see Section 4.9.1), so interviews were centred on these three key areas.

Interviewing vulnerable, older people can be particularly challenging due to their often weak physical and/or emotional well-being. Whilst some interviewees were under the age of 60, they had all experienced a significant challenge or crisis, so were considered to be vulnerable. It was therefore important for me to be sensitive and ensure the dignity of participants was maintained at all times. Being a disempowered group, I felt it was important that the interviewees were able to exert some control over the direction of the interviews by becoming “active subjects” (Russell, 1999). Every effort was made to ensure that the interviews were collaborative, communicative events with social interactions being jointly structured by myself and the participants (Hammersley and Atkinson, 1996).

Some interviewees were even able to derive their own benefits from the interview including using the interview as a chance to ask me questions (although I was not always able to answer them so signposted them to the appropriate people/organisation). For others, the interview appeared to be an opportunity to express their views and tell their life stories to an “independent and sympathetic listener” (Peel and Wilson, 2008), as well as a chance to relieve social isolation. Some interviewees would keep me talking for hours; showing me photos, certificates etc. and reminiscing about past events. Widowed participants often used the interview as an opportunity to talk about their deceased partner and appeared to find this process therapeutic. These are all common features identified when researching frail, older people (Russell, 1999; Bondi, 2003) and I felt this to be important in building a rapport with participants but also ensured that a non-hierarchical interview was undertaken. It also led to some rich narrative data that was not part of the original interview guide.

The interviews took place at a household rather than individual level and therefore interviews were often with more than one person. Members of a household tend to have a shared life history so activities, patterns and decisions are negotiated jointly (Allan, 1980), and therefore by interviewing at a household level these complex household relationships and interactions can be explored resulting in richer, more detailed and validated accounts (Valentine, 1999). The household structure of older adults can vary and are often subject to regular changes, often as a result of bereavement or increased dependency. Furthermore, as a person ages they are less likely to live alone; with those over 85 years old being the most likely to change household structure, usually to one where they can be cared for (Pendry *et al.*, 1999). The household structure of approximately half of the older interviewees had changed in recent years, as for example they had moved in with their children or a nursing home following bereavement. By taking a household approach, interviews were diverse and conducted with individuals who lived alone (as single, divorced or widowed people), with married couples, with those living with their daughter, those living with extended family and those living in a nursing home.

Whilst household interviews can have the benefit of generating shared life narratives and allow the interviewer to understand household relationships and roles, they can also bring some difficulties. As interviews take place with more than one person at a time, one member of the household may dominate leading to a one-sided interview. From a Feminist perspective, it may even lead to the disempowerment of women in the interview. In addition, members of a household may disagree on an issue, leaving it up to the interviewer to decide whose account to believe. Furthermore, as Valentine (1999) argues, household interviews can create moral or ethical dilemmas for the researcher as one person may make a disclosure which violates the privacy or consent of another interviewee. It may also be difficult to ensure consent is gained from all members of the household who take part in the interview, especially if going through one member who acts as a gatekeeper.

Whilst these concerns were taken into account, all respondents were given the option of being interviewed as a household as they were often very frail, with some being unable to speak for long periods of time. Therefore, household interviews allowed their stories to be told through other members of their household. This led to a range of different interview arrangements as shown in *Fig. 4.4*, which illustrates the different types of household structures of respondents and the number of interviews conducted with each type of household. A total of 20 households were interviewed; thirteen being interviews with individuals (one of whom was married but his wife was unable to take part in the interview), four with a married couple and three with other family members. For those interviewed as a couple, the emphasis was on their shared life narrative (Allan, 1980) and for those interviewed with other family members present the emphasis was on the narrative of the participant as part of the wider household. Two of these were with the participant's daughter due to the ill health of the participant (permission had been sought from both the participant and daughter). One of these interviews was over the phone from the UK as it was not possible to meet in person during the short fieldwork visit. These were the narratives of the participant told from the daughter's point of view, which whilst a limitation, still tells the participant's story from within a household perspective.

Using a proxy is common in research with older people, due to poor physical and mental health (Peel and Wilson, 2008).

***Fig. 4.4 – The Household Structure of Interviewees***

<b>Type of Household</b>	<b>Number of Interviewees</b>
Married Couple (Couple interviewed)	4
Married but individual interviewed	1
Divorced (Individual interviewed)	3
Single (Individual interviewed)	1
Widowed (Individual interviewed)	7
Nursing Home (Individual interviewed)	1
Lives with extended family (Interview with the participant and four family members)	1
Lives with/near daughter (Interview with the daughter only)	2
<b>Total</b>	<b>20</b>

The interviews were all conducted in the participants' homes and this gave context to the interviews, as seeing where someone lives allowed me to further understand their identity and lifestyle. For example, it was possible to identify if a participant lived a more Spanish or British way of life by for example having British food, television and furniture in their home. This was recorded as part of a research diary and made the narratives more meaningful. Interviewing people in their own homes was always the choice of the participant and made them feel at ease during the interview. The interviews lasted between half-an-hour to over two hours each. The longer interviews were with those who were very comfortable talking to me and most had experienced numerous and complex problems. On the other hand, shorter interviews were with those who had experienced fewer problems, or with those who were particularly frail and unable to speak for long periods of time. Interviewees were encouraged to "tell stories" because this not only provided a rich source of data, but also provided a frame of reference to aid



recall (Peel and Wilson, 2008). The interviews were recorded using a digital recorder (with permission from the participants).

The interviews followed a broad interview schedule (see Appendix 2) based on the defined themes of moving to Spain, social networks, challenges encountered and the future. Whilst the interviews generally followed these themes, the interview guide simply acted as a set of prompts rather than a rigid set of questions asked to every participant in the same way. This meant that the agenda was largely set by the participants who were encouraged to talk about those issues most important to them and as such tell their stories. Bryman (2004) argues that it is important to be flexible in interviews in order to respond to the direction taken by the interviewees, so that the emphasis of the research can be adjusted as a result of the significant issues that emerge. This is extremely important in the generation of narratives and as such every interview included different issues. When asking questions, I ensured that I used appropriate language, because as Grenier (2007) points out, younger and older people often exhibit different ways of speaking. I therefore ensured that questions were asked using simple terminology, without any jargon, for instance I avoided the use of “social network” and instead asked about “the people important to you now” as used successfully by Spencer and Pahl (2006) to obtain the social networks of participants in their research. Probing questions were then used to ensure participants thought about all aspects of their social network (friends, family, neighbours, volunteers etc.) and the nature of support they offered by asking questions such as “In what circumstances do you see this person?”

#### ***4.6.3 Recruiting Interviewees***

Interviews were conducted with households in the Costa Blanca, Costa del Sol and Mallorca. Six households were recruited through Stage One i.e. following up from enquiries made to Age Concern España. More were not recruited this way as some enquirers did not provide their contact details (often because volunteers did not feel comfortable asking for them). The remaining 14 households were recruited through Age

Concern España by asking volunteers to provide an anonymised list of their service users whom they considered to be suitable for inclusion. The list included some key personal characteristics and an overview of the challenges they had encountered which allowed me to select the most suitable participants. A list of potential interviewees was then drawn up and those who had not encountered any significant challenges and were not considered to be vulnerable were excluded resulting in a final list of approximately 35 households. Each selected interviewee was then contacted by phone (either by myself or an Age Concern volunteer), however a number of possible interviewees were not contactable (possibly due to their phone number being recorded incorrectly or due to them being away for long time). Whilst every participant who was contacted did agree to be interviewed, the time lapse between the survey and interviews meant that some interviewees were unavailable during the fieldwork period, sometimes due to a severe decline in health or admittance to hospital. One lady actually died before the interview was set up! Recruitment therefore proved quite difficult and very time consuming, yet does highlight the extreme frailty and vulnerability of the research population.

In the Costa Blanca eight households were interviewed, all within the Torrevieja area. In Estepona, seven households were interviewed, across a wider geographical area of approximately 50 miles ranging from Estepona to Malaga. In Mallorca five households were interviewed across areas largely concentrated on the South West and North East coasts. The number of interviewees in each location largely reflects the differences in the total number of British people living in each area (based on figures from Instituto Nacional de Estadística, 2007). Whilst representativeness of the sample was not essential, every effort was made to ensure that a sample of variability was recruited with a mix of genders, social class backgrounds, ages, marital status and time lived in Spain. The following tables show the key characteristics of the interview participants from each location.

**Fig. 4.5 - Interviewees in Mallorca**

<i>Interviewee</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>
<i>Individual (I)/ Couple (C)/ Family (F)</i> <sup>9</sup>	F	I	C	I	I
<i>Age</i>	76	72	86/80	90	62
<i>Gender</i>	F	M	M/F	F	M
<i>Marital Status (see Fig. 4.8)</i>	W	D	M	D	M
<i>Years in Spain</i>	30	22	19	30	4

**Fig. 4.6 - Interviewees in the Costa Blanca**

<i>Interviewee</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>	<i>6</i>	<i>7</i>	<i>8</i>
<i>Individual (I)/ Couple (C)/ Family (F)</i>	I	I	C	C	C	I	I	I
<i>Age</i>	86	78	81/81	69/67	81/87	83	66	79
<i>Gender</i>	M	F	M/F	M/F	M/F	F	F	F
<i>Marital Status</i>	W	W	M	M	M	W	W	D
<i>Years in Spain</i>	1.5	18	4	5	20	21	6	16

**Fig. 4.7 - Interviewees in the Costa del Sol**

<i>Interviewee</i>	<i>1</i>	<i>2</i>	<i>3</i>	<i>4</i>	<i>5</i>	<i>6</i>	<i>7</i>
<i>Individual (I)/ Couple (C)/ Family (F)</i>	F	F	I	I	I	I	I
<i>Age</i>	87/93	93	74	89	68	51	80
<i>Gender</i>	M/F	F	F	F	F	F	M
<i>Marital Status</i>	M	W	W	W	W	W	S
<i>Years in Spain</i>	9	14	34	19	6	7	18

<sup>9</sup> Indicates if interviews were conducted with an individual person (I), a couple (C) or with family members present (F).

*Fig. 4.8—Marital Status Key*

W	Widowed
D	Divorced
M	Married
S	Single

As the above tables show, there were 16 female participants and only nine males (when couples are counted as two participants) which may be due to more women being service users of Age Concern España, as indicated by 58% of enquirers from Stage One being female. This could be explained by Dwyer and Hardill's (2008) research which suggests that men are more reluctant to engage with local support services such as Age Concern. This does indicate a gender bias in the sample; however, the higher life expectancy of females does mean that women are more likely to live to old age and also to be widowed. This is indicated by nine out of the ten widowed interviewees being women.

The average age of all interviewees was 78.25, however the age range was between 51 and 93 and therefore covers those just entering old age to those distinguished by an increasing vulnerability to ill health or declining mobility (as defined by DoH, 2001). All participants were however considered to be vulnerable according to the criteria discussed above. All participants lived in Spain for at least 9 months of the year (with most living there all year round) and the number of years lived in Spain ranged from one to 34 years and therefore captures the problems associated with a recent move to Spain, as well as those who have "aged in place" and this was felt to be very important.

## **4.7 Ethnographic Observations**

Ethnographic observations were undertaken throughout the research process to inform the research design and to collect contextual data. Observations were therefore used to gain an understanding of the physical, social, cultural, and economic contexts within which

older British people in Spain live; including the relationships among and between people, ideas, norms, and events, as well as people's behaviours and activities (Mack *et al.*, 2005). They therefore helped me to understand the cultural environment within which research participants are located. Therefore, during every fieldwork visit, observations and informal conversations were held with Age Concern organisations, volunteers, paid staff and service users. Observations of the local communities within which the Age Concern organisations were located also provided context and meaning to the research and enabled a broad understanding of the lives of older British people in Spain.

During the fieldwork periods I spent approximately five months living in Spain (see Section 4.4.4), so this allowed me to immerse myself in the life of a British expatriate. Whilst observation was not in itself a research method for this study and are not presented as research findings, they became an essential tool to develop the research and to allow the exploration of life in Spain for British people. This follows from O'Reilly (2000a) who successfully used participant observation to research British people in Spain. Her data was generated from experience and participation rather than merely observing. During the fieldwork periods I lived the life of an expatriate, which included making friends with British people, going for dinner at the houses of other British people, attending social club events as well as local Spanish events. Informal interviews were undertaken in the form of general conversation and interaction (O'Reilly, 2000a), which were recorded as part of an informal fieldwork diary. By immersing myself in the lives of the participants, it was possible to understand the cultural context within which they were located, for example when interviewees discussed local events or places it was not necessary to ask them to explain what they were. This enabled me to discern subtleties within participant responses and ask appropriate follow up questions (Mack, *et al.*, 2005). This also improved the quality of the interviews by improving the rapport between myself and the interviewees.

During the preliminary fieldwork visits, observations were also used to understand the Age Concern organisations and how the research would be situated within it. This informed my choice of methods and sample selection criteria as it was possible to

establish a good understanding of the study location and participants. For instance, through observing the Age Concern centre, it was possible to estimate the number and type of respondents and so develop more effective research tools. It was also used to facilitate relationships with gatekeepers and key informants who were essential in identifying and gaining access to research participants. The observations are therefore not presented as data in this thesis as they were used to develop the research methods, data collection tools and in exploratory work.

#### **4.8 The Case Study Design**

Whilst the study employs both quantitative and qualitative data, the overall approach is primarily qualitative used to uncover the experiences of older British people in Spain. The research was undertaken as a case study, located within a critical humanist framework. Critical humanism has been utilised by Plummer (2001), who outlines its five central criteria:

1. It shows how individuals respond to social constraints and actively assemble social worlds;
2. It deals with concrete human experiences – talk, feeling, action;
3. It shows a naturalistic 'intimate familiarity' with such experiences;
4. It takes seriously the idea that knowing, which is always limited and partial, should be grounded in experience;
5. It moves towards a sociology which is of less exploitation, oppression and injustice and more creativity, diversity and equality.

This approach is taken forward in this thesis through the use of narratives (as discussed above) as part of a case study design. Robson (2002:178) defines a case study as “a strategy for doing research which involves an empirical investigation of a particular contemporary phenomenon within its real life context using multiple sources of

evidence”. They are commonly used in both social and policy research due to their ability to investigate real life situations and highlight links between policy and outcomes for individuals (Yin, 2003). They are often associated with a location, in particular a community or organisation (Bryman, 2004). This includes O’Reilly’s (2000a) research on a community of British people living in Spain which is a frequently cited example of a case study (e.g. Bryman, 2004). This thesis adopts a similar approach with the use of a single area case study of the “older British community in Spain” across multiple sites, with various individual sub-cases informing theories of transnational life and ageing. The purpose of the case study is not to test theory or hypotheses but to use the data generated to engage in theoretical analysis. This was the approach taken here with the research being firmly located within the inductive tradition (Bryman, 2004).

Using an inductive approach allowed flexibility, not only in the research design, but with the key concepts, allowing ideas to emerge as data is collected. British people in Spain are an extremely heterogeneous group who are difficult to define, as shown by O’Reilly (2000a) whose research challenges existing assumptions about British people in Spain. She did not set out to test a theory or a hypothesis and instead brought theory and concepts to the study in light of subsequent observations and the revision of key concepts, including ‘migration’. This study adopts the same approach whereby:

Theories and concepts are applied where they help to unravel the webs of significance or explicate complex interpretations, when they enable thick description; they are discarded at points where they fail to make things clearer (O’Reilly, 2000a:10).

Literature was therefore used to inform the research design and research questions with theories emerging as data was collected. The central heuristic framework applied to the data was that of ‘Grid and Group’ (discussed in Section 2.3), which is used to underpin the analysis on social networks. Furthermore, the issue of transnational social networks became significant to the understanding of migration patterns and the development of social networks across national boundaries. By bringing together key concepts,

significant and new theoretical insights have been uncovered into the experiences of older British people in Spain. Grid and group theory has been modified to answer the specific research questions posed in relation to both migration and social networks, and underpins the data analysis in the social network chapter (Chapter Five).

As Yin (2003) points out, the generalisation of results in a case study is made not to populations but to theory, and this has brought criticism of case studies due to their lack of generalisability. Deem and Brehony (1994) found that case studies have been criticised for their inability to guarantee reliability and validity of data interpretations and also since the case study relies heavily on interactions between people, there is always the possibility of bias and prejudice in the way data is collected and analysed. These are common criticisms of qualitative research generally. However, in reply to its critics the purpose of qualitative research is not to generalise to populations as a whole, but instead to investigate phenomena in-depth with the view to understanding the meanings and voices of participants. Some case study researchers reject issues around reliability and validity as inappropriate (Bryman, 2004), whilst others such as Yin (2003) suggest ways in which case studies can be improved to meet such criteria. However, either way, the purpose of case studies is not to generalise or to elicit “true” accounts of reality, but instead to investigate real-life people in their real-life context. As such a subjective account of reality is generated. This forms the basis of the narrative approach used in the interviews.

## **4.9 Data Analysis**

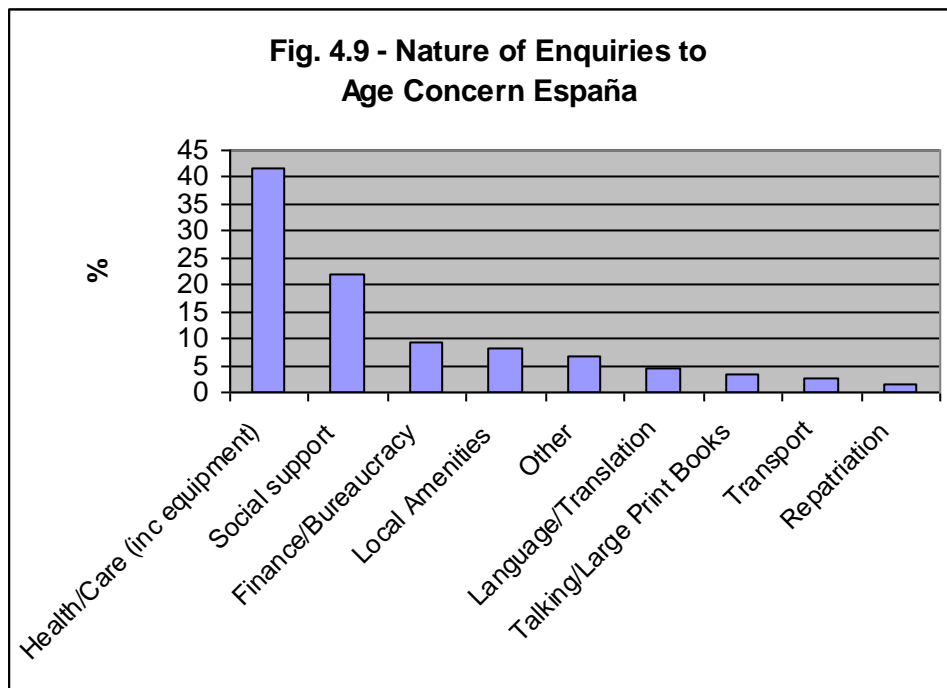
This section discusses the data analysis techniques employed in Stages One and Two, which includes both quantitative and qualitative approaches. It begins with the analysis techniques employed in the survey of enquiries and the ways in which this was used to inform the interviews. This discussion includes the key findings from the survey of enquiries.



#### 4.9.1 Stage One – The Survey Analysis

The data from the survey of enquiries was analysed quantitatively using SPSS. Answers to each question were coded, and SPSS was used to generate frequency and comparison tables. This data underpinned the entire thesis as it sensitised me to the main issues explored in the interviews including the main challenges encountered by older British people in Spain. The survey identified three main challenges which form the basis of the analysis chapters; health/care, social and financial. This supports previous research which suggests that a lack of social, health and financial resources can result in vulnerability and a poor quality of life in old age (e.g. Gabriel and Bowling, 2004; Grundy, 2006).

The survey was based on the analysis of 503 enquiries to Age Concern España over the four-week survey period (from 435 enquirers as some enquirers asked about more than one thing). *Fig. 4.9* shows the nature of all enquiries received with the main types of enquiries being centred on health/care, social and financial needs.



### *Health/Care*

Health and care enquiries were centred around requests for information on health and/or care services in Spain. The theme of health/care included the survey categories of health and care, as well as equipment hire. Equipment hire was usually the hire of wheelchairs and walking aids by those with health and mobility problems so was therefore considered an enquiry directly related to health and care needs. These three types of enquiries together made up 42% of all enquiries, representing a significant area in which older British people are facing challenges. This supports previous research which highlights the negative impact of poor health and mobility in old age (Higgs *et al.*, 2003). Health/care therefore became one of the key areas for further investigation in the in-depth interviews.

### *Social Support*

Nearly a quarter (22%) of enquiries were for social support. Such enquiries were frequently from widowed clients who were suffering from loneliness or isolation. Maintaining social connections including links with family, friends and the community is vital to successful ageing, with a lack of social support being linked to increased vulnerability (Grundy, 2006). The survey therefore identified a high level of social need among older British people in Spain and as such social networks and support became the second area for further investigation in the in-depth interviews.

### *Finance*

The other key areas in which people were encountering significant levels of need were finance and bureaucracy. Whilst these initially formed two separate categories in the survey, they were strongly linked as most bureaucracy enquiries were on the rules surrounding UK benefits and pensions, as well as other financial issues. As such,

financial issues were considered to be a significant area of need as together these made up 9% of all enquiries. This supports previous research which suggests that financial difficulties are especially common during old age as most retired people live on fixed incomes (Grundy, 2006) and as such are a contributing factor to vulnerability. Finance therefore formed the third main area for further investigation in the in-depth interviews.

Whilst enquiries were also made on local amenities, translations and transport, these were not areas deemed large enough to be considered on their own. However, these were issues mentioned by interview participants and as such are discussed within the three data analysis chapters.

#### ***4.9.2 Stage Two – The Interview Analysis***

Narrative analysis was performed on the interview data, with the purpose being to emphasise the stories that participants told (Bryman, 2004). This began with the transcription of interviews into “clean” transcripts which recorded only the words spoken (Elliott, 2005), with the purpose being to undertake thematic analysis which focused on the content of the narrative rather than its form (i.e. what is said rather than how it is said) (Reissman, 2004). This allowed me to reduce each participant’s responses to a set of common themes that were compared to other participant’s stories, and to existing theory on ageing.

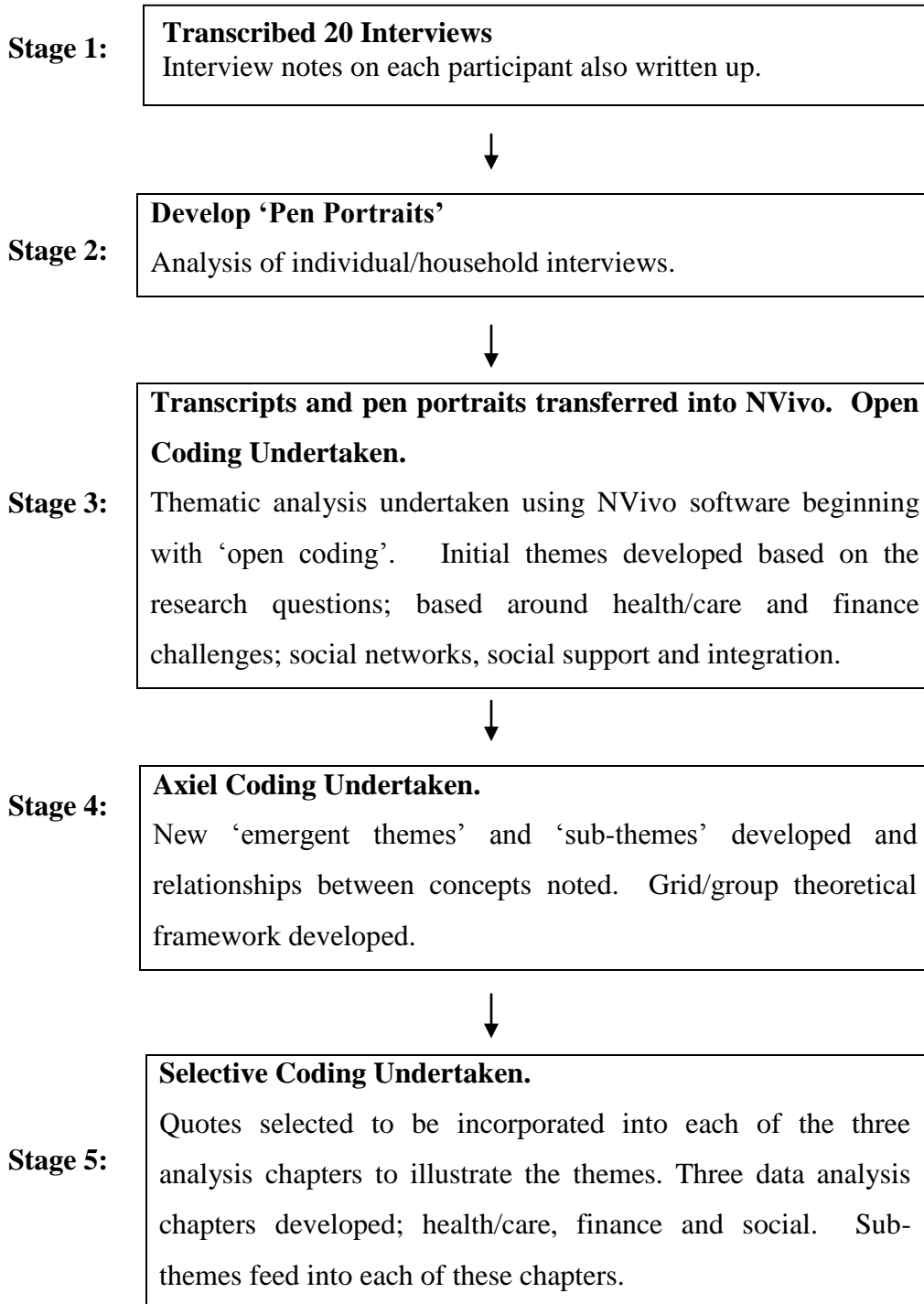
Additional notes were however written for each participant about the ‘interview situation’ including body language, location and context which were used to provide meaning to the interviews. These notes were recorded in the fieldwork diary, along with notes from the ethnographic observations. Using the fieldwork diary and from reading the interview transcripts, ‘pen portraits’ of every interview participant were written. These gave an overview of each participant’s characteristics and their ‘narrative story’ using a range of basic thematic headings based on the research questions e.g. challenges encountered,

social network (family, friends) (see Appendix 4 for an example pen portrait). At this initial stage, the analysis was done on an individual/household level in order to generate an overview of the findings and was used to uncover key emergent themes in the data.

The transcribed interviews and pen portraits were then entered into QSR N6 for coding and further qualitative analysis. A coding framework was devised based on both the theoretical interests guiding the research questions, as well as on the salient issues and recurring ideas that arose in the text itself (Attride-Stirling, 2001). Coding was undertaken in three stages, as defined by Fielding (2008). First, ‘open coding’ was undertaken which dissected the text into text segments based around the coding framework. The initial coding framework was developed using emergent ideas from the survey of enquiries and pen portraits, based around the nature of challenges within three categories; ‘health/care’, ‘finance’ and ‘social’. ‘Social network’ data was also coded based around different types of relationships. i.e. friends, family, neighbours. Some additional codes were developed based around the research questions and literature, as well as recurring patterns which included ‘integration’, ‘moving to Spain’, ‘returning to the UK’, ‘bereavement’ and ‘transport’. Searches using N6 were also undertaken on these key words to ensure that no data had been excluded.

The data was then examined for a second time to create ‘axial codes’, which involved analysing the relationships between codes and developing sub-categories (using the ‘tree nodes’ function in NVivo). Similar categories were grouped together and larger categories sub-divided, which developed a “web of relationships” (Fielding, 2008:348). At this point, some clear themes and concepts emerged from the data. This included the emergence of different types of participants based on their social network types and amount of regulation/constraint. This provided a unique theoretical insight based around the grid/group framework. The third stage of coding was ‘selective coding’ which involved “scanning both the codes and the data and then selecting cases to illustrate major themes uncovered during open and exile coding” (Fielding, 2008:348). The quotes selected during this stage were incorporated into each of the three analysis chapters to illustrate the themes. The qualitative analysis is illustrated in *Fig. 4.10* below.

*Fig. 4.10: Illustration of Qualitative Analysis*



#### 4.10 Research Ethics

The project was conducted within clear ethical procedures and guided by the Nottingham Trent University Graduate School's code of guidance and was approved by the University Faculty Research Degrees Committee. It was also carried out to the standards set in the ESRC's Research Ethics Framework (ESRC, 2005) and the British Sociological Society's Statement on Ethical Practice (British Sociological Association, 2002). In accordance with these guidelines, the research was conducted with the welfare of participants in mind.

As mentioned above, research with frail, elderly people is often avoided because of ethical concerns (Peel and Wilson, 2008). The biggest ethical dilemma is around gaining informed consent (Bowsher, *et al.*, 1993). Informed consent involves ensuring that all research participants are given as much information as might be needed to make an informed decision about whether they wish to take part in the research (Bryman, 2004). Gaining informed consent from older, vulnerable participants has been noted as particularly problematic because lonely older people may only consent to be interviewed because of the social interaction it provides (KayserJones and Koenig, 1994) and if this is the case, participation is not truly voluntary. Whilst in Stage One this was not an issue as it did not involve interviewing, ensuring voluntary participation was essential for Stage Two. Only those interviewees who were felt able to consent for themselves were asked to take part, and as such this excluded those with mental health problems. An information sheet (see Appendix 3) was provided to all interviewees prior to the interview commencing and all participants signed an informed consent form (see Appendix 3). Interviewees were also given a cooling off period of at least two days between being approached for interview and the interview actually taking place. Participants were reminded of their right to withdraw from the research at any time and that they did not have to answer any question which they would rather not. They were also provided with my contact details if they had any questions or wished to discuss any issues.

For Stage One, every effort was made to ensure that service users were aware of their enquiries being recorded by putting up notices in the Age Concern centre and asking permission to record personal details (e.g. age, marital status) (see proforma in Appendix 1). If enquirers did not want their personal details recorded they were asked if they were happy for their enquiry to be recorded and if they also said no to this, their enquiry was excluded.

Confidentiality and anonymity during data collection are also important and this includes how data is both stored and disseminated (Gilbert, 2008). This was ensured at every stage of the research, with all data being treated as confidential and stored in a locked filing cabinet and/or on a password protected computer. Interview recordings were deleted from the digital voice recorder as soon as they were transferred to a password protected laptop. As mentioned above, I did not approach any participants for interview who had not previously given me their permission to do so as this would be considered an invasion of their privacy and breach of Age Concern's confidentiality policy. As such, service users put forward by Age Concern were initially approached by a volunteer who asked if I could then contact them. This gave them an opportunity to say no before being approached directly by me. All participants at every stage remained anonymous with pseudonyms being used for interviewees and no names or recognisable details taken from proformas without permission. Any recognisable details recorded, especially permissions to be approached for interview, were separated from the proformas and identified using a code system. Confidentiality proved to be a big concern for some organisations during Stage One, in particular Menorca, whose volunteers did not want to ask for any additional information from enquirers, resulting in a large percentage of unrecorded additional information. This was due to their confidentiality policy, which they interpreted differently to other organisations and it was not possible for me, as a researcher, to change existing organisational policy.

One area of ethical concern was of harm to participants as the BSA Statement of Ethical Practice (2002) advises that researchers "should consider carefully the possibility that the research experience may be a disturbing one" (BSA, 2002). This is especially so for

vulnerable interview participants including the elderly or those with poor health. As most of the interviewees were elderly, had poor health and/or had experienced a recent crisis they were particularly vulnerable and needed to be treated with care. As such, questions were worded so as to avoid upset and participants were advised to tell me only what they wished to. The narrative method employed made this possible as the interviews were the stories of participants told from their own point of view. On a few occasions, interviewees became distressed or upset and when this happened I asked them if they wanted to stop the interview. However, on every occasion, the interviewee wanted to carry on as they told me they liked to talk about the difficulties they had faced and some found it rewarding to “tell their story”, which is a key feature of the narrative approach. This is supported in Bondi’s (2003) research, which found that interviews are often an emotional experience from which interviewees are able to seek therapeutic benefits.

#### **4.11 Research Reflections**

As a researcher looking to understand the social context within which my participants are located, it is important to consider my own role in the research. During the fieldwork periods I spent approximately four to five months living in Spain (in short blocks of time), so this allowed me to immerse myself in the life of a British expatriate. This involved undertaking ethnographic observations as discussed above. Observations were not initially a feature of the research methods employed, however they became very important in all aspects of the research, including in the study design, data collection and interpretation of the findings. They enabled me to explore life in Spain for British people and provided contextual and culturally specific information.

On a personal level, my interest in the topic of retirement migration stemmed from the fact that my own parents live in France. Having seen the challenges they (and their British friends) have encountered whilst living abroad, I was keen to look at the topic in more depth. This was something I often mentioned to both research participants and



volunteers, and appeared to break down my status as an “outsider” (Grenier, 2007). Whilst my status as a ‘young person living in the UK’ sometimes left me feeling an outsider, my own lived experience of living abroad through my parents gave me essential insights and in doing so enabled me to build credibility and rapport and improved the information shared, which has been shown to provide a more reliable account (Brah, 1992 cited in Grenier, 2007).

To give me further insights into the life of an expatriate and to help me to build up a good working relationship with volunteers and service users (and therefore develop ‘insider’ status), I undertook the role of an Age Concern volunteer whilst in Spain. This included working in the shop and centre by sorting through donations, working on the cash desk etc. I felt that it was essential to develop reciprocal relationship with volunteers whereby I offered something in return for their help in conducting the research. My role as a volunteer did lead to some participants thinking of me as a volunteer of Age Concern España rather than a researcher (despite my explanations otherwise). This generated a more positive response from some participants. However, it also meant that during the interviews participants asked me questions as they would other volunteers which took up time and also left me in the difficult position of not being able to answer some questions due to my lack of local knowledge. In these situations, I referred participants back to the Age Concern organisation.

Whilst working with volunteers was very rewarding, this did also prove difficult at times. The informal nature of volunteering often means that for some volunteers, the time they spend at Age Concern is more of a social event rather than ‘work’. Volunteering has been shown as a strategy to develop social networks, and to access information, opportunities and social status (Hardill *et al.*, 2007), and this often takes precedence over undertaking actual work. As such, I found that being engaged in research was not a priority for some volunteers. I did my very best to engage with the volunteers by developing a rapport and undertaking any jobs that needed doing; however, some volunteers did not understand the value of the research or were simply not interested in helping. As unpaid volunteers it is not possible to issue orders as it is to a paid worker,

because if they became upset, they could leave and this in turn would cause problems for Age Concern.

One area of concern for volunteers was asking service users for personal details to record on the proforma, as some volunteers felt uncomfortable asking questions such as “what is your age”? Whilst in reality participants are generally less embarrassed about answering sensitive questions than researchers are about asking them (Hoinville and Jowell, 1985), it was not possible to instruct volunteers to do something they felt uncomfortable with, and this led to a small number of uncompleted proformas. As such, there was a need to take an informal and sensitive approach to managing volunteers. The volunteers (particularly the Presidents and co-ordinators) at every Age Concern España organisation are also busy and some work long hours, and therefore the research was often not a priority to them. This resulted in some delays in receiving the data from organisations, for instance following the first recording stage in Mallorca, I did not receive the completed proformas for three months because the volunteer recording the enquiries had ‘lost’ the proformas under a pile of other work.

The interviews also presented a number of challenges, the main one being the recruitment of participants. Due to the nature of the research, the sample population was a very sensitive one with a number of participants being in poor health, recently widowed or facing another significant problem. This in turn led to ethical issues, short interview times and difficulty recruiting. As mentioned above, some selected participants were unable to take part in an interview due to ill health (or on one occasion death!) and some were excluded due to mental health problems. This led to the list of potential interviewees being quite small (approximately 35 households) and as such the choice of participants was limited. Whilst working with Age Concern certainly helped with the recruitment of participants, it also brought some problems. By using Age Concern volunteers as gatekeepers they had a significant input into the selection of participants, and for the interviews in particular a subjective judgement was made over which service users they would like to be interviewed. Gatekeepers are often shown to direct researchers to a narrow selection of interviews based on their own judgements (Sanghera

and Thapar-Bjorkert, 2008) and this appeared to be the case here. Whilst I felt that some service users would be suitable, at times volunteers did not want me to approach them as they felt that their problems were not relevant or that they would not want to be interviewed. Russell (1999) found that service providers often deny researchers access to their elderly, frail clients due to a fear they may be upset, or that the researcher may jeopardise their own (often hard-won) rapport with their clients, and the same appeared to be the case here and led to a more restricted interview sample.

## **4.12 Summary**

This chapter has recounted and reflected on the research process. In doing so, it has explained how a narrative approach has been employed to examine the lived experiences of older British people in Spain. It has discussed the two main research stages, and shown how the survey of enquiries to Age Concern underpinned the thesis and informed the in-depth interviews. It has also discussed the importance of ethnographic observations throughout the fieldwork period. As a CASE studentship, Age Concern were engaged in the research process from defining the aims to disseminating the findings. In addition to this PhD, the research findings have been disseminated back to Age Concern through two reports. The first report for Age Concern España was used to provide evidence on the nature of enquiries received by the charity to improve and develop local services in Spain. A report was also produced for Age Concern England detailing implications of the research findings for UK, Spanish and EU policy. The key findings from these reports are discussed in Section 8.4.

The thesis now moves on to present the analysis of the data gathered. The findings are presented in three chapters based around the main challenges facing older British people in Spain: Chapter Five is social networks and support; Chapter Six is health and social care challenges; and Chapter Seven is financial challenges. In each of these chapters, data is drawn from the in-depth interviews using interview quotes and case studies to detail the lived experiences and stories of participants.

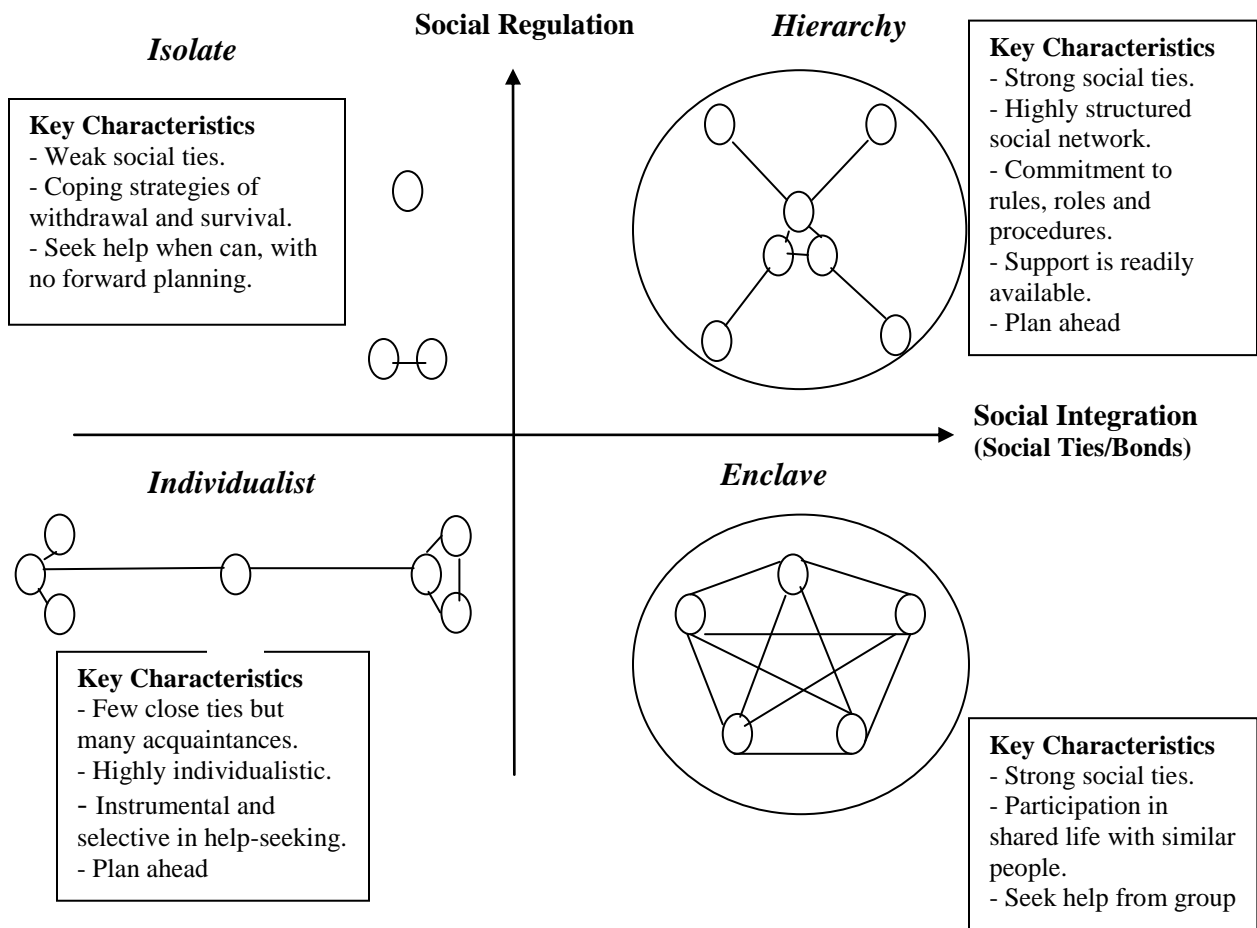
## Chapter 5 - Social Networks and Support

This is the first of three data analysis chapters and focuses on the second research aim by exploring the support networks that interview participants construct in Spain and the UK (or elsewhere), and the role that they play during times of crisis. It focuses on the nature of informal social ties with family, friends and neighbours, as well as ties and networks with community and voluntary organisations, including Age Concern España. The chapter also examines where networks are located, and in doing so identifies the extent to which respondents are transnational. As noted in Section 4.9.1, social support was identified in the survey of enquiries as a significant difficulty facing older British people in Spain (22% of all enquiries to Age Concern España) with many such people experiencing isolation and loneliness. Isolation and loneliness were found to be especially prominent amongst those who are widowed. These findings are explored further in this chapter using data from the interviews.

The interviews initially explored respondent's social networks, before looking at how and when these networks were utilised for support, especially during times of crisis and vulnerability. The Grid and Group theoretical framework was utilised to categorise respondent's social network configurations (see Section 2.3.1 for further detail on the framework). This framework was used as it captures not only individual factors and networks, but includes the wider socio-cultural context within which respondents are located. Utilising the framework therefore allows an exploration not only of respondent's networks, but of their wider social, cultural and political environments, including the impact of cultural and language differences, as well as local, national and international policy. The framework established four distinct types of social network organisation; Isolate, Hierarchy, Individualism and Enclave (see *Fig. 5.1*). Each of these types are presented in this chapter. The presentation of the data for each type begins with an overview of the features of each respondent, which is provided in a table summarising their key characteristics. This is followed by the story of a typical case within that type.

Whilst this framework identifies four ideal types, some people live under hybrid forms (Hardill *et al.*, 2007) with respondents possessing characteristics from two or more groups. In addition, some movement between types was noted, especially as an individual ages and their circumstances change. This therefore captures the complexity of life, especially during old age. The four types of social organisation are now discussed in turn, beginning with the Isolates. Each type is presented using indicative case studies and quotes from participants to highlight lived experiences.

**Fig. 5.1 – Grid and Group Diagram**



*Source: Adapted from Hardill, Baines and 6 (2007:401)*

## 5.1 The Isolates

### 5.1.1 Common Characteristics of the Isolates

In the top left quadrant of *Fig. 5.1* are the weakly integrated but strongly regulated “Isolates” (Douglas, 2005). They are especially vulnerable to isolation and loneliness as they have few social ties and limited networks other than a few longstanding friends, neighbours or family members (Hardill *et al.*, 2007). They therefore have limited social capital and are constrained from taking part in social events both in Spain and the UK. However, where social ties do exist, a high level of dependence is frequently placed upon them. In addition, they are heavily constrained by formal rules and regulations, as well as by limited physical and financial resources. They often feel that they do not belong, and in other research have been identified as “getting by” (Hardill *et al.*, 2007). They employ coping strategies for survival with any resources or opportunities they encounter and often rely on others to generate support for them. They are an extremely vulnerable group with a poor quality of life. This section examines the key themes of lack of control, dependence on others, isolation and a poor quality of life.

The key characteristics of the Isolate interviewees are shown in *Fig. 5.2*. A significant characteristic is age as they were the oldest age group, with an average of 84.6 years. Whilst their ages ranged from 74 to 93 years, of the eight Isolates, five were over the age of 85. This means that they are in the “fourth age” of dependence and decline (Laslett, 1991) and therefore their age does make them especially vulnerable. As would be expected, most have considerable health problems and are in need of care. The majority (six out of eight) are widowed which contributes to their high levels of social isolation and loneliness. All Isolates had been living in Spain for between 18 months and 34 years, however the average was 16.8 years which was the longest of all four types. They all spent 12 months of the year in Spain. Three Isolate households lived in the Estepona area, two in the Torrevieja area and two in Mallorca. One lived in a Spanish nursing home and three of these households lived with their daughter in Spain. The daughters of these Isolates are themselves ‘older people’ as defined in this study, i.e. over the age of

50. However, they were not retired and as this is a study of retirement migration, they were not counted as participants in their own right. Instead, their stories were captured as part of the household interview with the focus being on the experience of the Isolates.

Within the Isolates there are two indicative types; those who moved out of necessity and those who moved out of choice. Those who moved out of necessity are the first four Isolates in *Fig. 5.2* (Lauren, Steven, Barbara and Harry) who live with or near to their daughter in Spain, and their key motivation for moving was to receive care from their daughter (moving for care is discussed further in Section 6.5.2). These participants appeared to be Isolates before moving to Spain, as they had limited social networks and high care needs in the UK which encouraged them to move to Spain to receive care from their daughter. On the other hand, the remaining four Isolates, Wilma, Elsa, Gabrielle and Sheila, moved to Spain out of choice, with the main motivation for moving being a better quality of life in Spain. This group did not have care needs and had good social networks whilst living in the UK, which suggests that they did not move as Isolates but became Isolates in Spain. This was mainly as a result of a decline in health and/or bereavement and the subsequent lack of support. Therefore, Isolate status can develop either before or after moving abroad. The analysis will begin by highlighting the lived experience of two Isolates; Barbara who moved as an Isolate and Elsa who became an Isolate in Spain. The stories of these two respondents are outlined in *Fig. 5.3* to highlight some of the key issues within the Isolate group, which are then discussed in the subsequent sections. This includes discussion on support, dependence and isolation.

**Fig. 5.2 – Key Characteristics of the Isolates**

	<b>Time in Spain</b>	<b>Residence</b>	<b>Reason for Moving to Spain</b>	<b>Family</b>	<b>Friends</b>	<b>Nature of Age Concern Support</b>	<b>Other sources of Support</b>
<b>Lauren and Steven (93/87) Married</b>	9 years	Live with daughter/son in law in isolated and hilly location.	To live with and be cared for by daughter.	Reliant on daughter in Spain.	No good friends in Spain or UK.	Daughter had contacted Age Concern England for information on repatriation.	None
<b>Barbara (93) Widowed before moving</b>	14 years	Lives in small flat owned by daughter.	To receive care from daughter.	Reliant on daughter who lives nearby.	No friends in Spain or UK.	Organising repatriation to UK.	Cleaner/carer for 3 hours/week.
<b>Harry (86) Widowed after moving</b>	18 months	Lives in Spanish nursing home.	To be cared for by daughter.	Daughter lives nearby who visits him regularly.	No friends in Spain or UK.	Weekly visits from volunteers.	Weekly visits from HELP (British charity) volunteers.
<b>Wilma (76) Widowed after moving</b>	30 years	Lives with daughter/son in law in small flat.	To live with daughter.	Dependent on daughter, son-in-law and grandchildren in Spain.	A few friends in Spain and UK.	Organised financial support.	None
<b>Gabrielle (89) Widowed after moving</b>	19 years	Lives in small villa on urbanisation.	Moved with husband for better weather.	Little contact with family in Germany. No children.	Close Spanish neighbour. Few other friends.	Take her to hospital and translate.	Cleaner for 2 hours/week. Tele-alarm from Social Services.
<b>Sheila (74) Widowed before moving</b>	34 years	Lives in small flat in town centre.	To work/ better quality of life.	Close to two daughters living in the UK.	A few friends in Spain or UK.	Organised financial support.	None
<b>Elsa (78) Widowed after moving</b>	18 years	Lives in small villa on urbanisation.	Husband wanted to move after retiring.	Close to daughter living in the UK.	Close neighbour. Few friends in Spain or UK.	Provide ongoing practical and emotional support.	None



### ***Fig. 5.3 – Barbara and Elsa***

#### The Experience of Barbara

Barbara is a 93 year old widow, who moved to Spain 14 years ago to be near her daughter Jane who already lived in Spain. She moved following a decline in her health and the need for additional care, which she wished to receive from her daughter, her main source of support. Barbara lives in a small apartment on the second floor of a large block. The apartment is owned by her daughter, who lives 30 miles away. Nearly two years ago, Jane and her husband separated leaving Jane with financial problems and needing to work full time. This meant that she could spend little time with Barbara. Unfortunately, around the same time Barbara's health deteriorated rapidly leaving her immobile, almost deaf and partly blind, and subsequently in need of 24 hour care. She became confined to the small apartment on her own, and the only person she saw was Jane who visited most days. Barbara has no family other than Jane and has no friends except one friend in the UK whom she has not seen for many years, so is totally dependent on Jane; financially, emotionally and physically. Whilst Jane can speak fluent Spanish, Barbara can speak none and therefore relies on Jane to translate. Jane has been unable to find suitable care for Barbara, and the only care available and affordable is a cleaner/carer for three hours per week who cleans the apartment and washes Barbara. As a result, Barbara and her daughter have asked Age Concern to organise her repatriation to a nursing home in the UK. Neither Barbara nor Jane want her to return as Jane will remain in Spain, leaving Barbara alone in a nursing home in the UK. The interview was undertaken with Jane, as Barbara was considered unable to partake in an interview due to deafness.

#### The Experience of Elsa

Elsa is a 78 year old widow who moved to Spain 18 years ago with her husband. Whilst it was her husband's idea to move, she spent a very happy 17 years in Spain where her quality of life and social life were better than in the UK. Unfortunately, after her

husband's sudden death one year ago, her quality of life has declined rapidly. She now has few friends as her social life was based around going out with her husband and his friends, so she is now very lonely and isolated. Her health has also declined considerably so she is unable to walk far, and her inability to drive means that she is largely confined to her home. With the exception of her daughter in the UK upon whom she is very reliant, her only support in Spain is from a neighbour and a few British friends that she sees occasionally. She also relies on a volunteer from Age Concern España to organise her accounts, and help her repay some large debts left by her husband.

### ***5.1.2 Dependence and Lack of Control***

#### *Family*

The Isolates were extremely frail and had poor health, both of which are significant contributing factors to vulnerability (Brocklehurst and Laurenson, 2008). They had high care needs and were physically and emotionally dependent on others. They did however have very limited social networks, where support could only be obtained from one or two close family members. Social support is a key resource to overcome old age vulnerability (Grundy, 2006) and this was something that the Isolates lacked.

The main or only source of support available to the Isolates was a close family member. Research has suggested that family are the most likely to provide care and support for vulnerable older people following a decline in health (Park and Roberts, 2002) and this was the case for the Isolates. This included the five Isolates who lived with or very near to their daughter in Spain and were reliant upon them for emotional, practical, physical and/or financial support:

When I went into hospital...for three weeks. I mean I was demented. My mum was on her own. It was just a nightmare. (Daughter of Barbara, 93, Widowed)

My daughter was home in the morning and we used to change [Wilma's husband] and wash him and then my son-in-law, the darling, used to come home every evening to help me because I couldn't do it you see. (Wilma, 76, Widowed)

The Isolates also had little control over their lives and frequently allowed or even expected their daughter to make decisions for them, which for Barbara included organising her care and repatriation to the UK. A further example of this is that two of the interviews were conducted with the daughter of the participants, as they were felt to be unable to speak themselves and therefore control of the interview was passed on to their daughter.

Wilma is also reliant on her family with whom she lives, as she is largely confined to the home unless her family take her out. This includes shopping and even social activities such as visiting a friend:

Saturday I go shopping with [daughter]. I go and get my hair done every Saturday afternoon. [Son-in-law] takes me and brings me back. (Wilma, 76, Widowed)

But the thing is, [friend] lives about 15 minutes away and when you get older you need someone to bring you to take you and all this, so it's not as easy. (Wilma)

Whilst those who live alone are less reliant on one family member, two such participants (Elsa and Sheila) have a daughter living in the UK upon whom they are dependent; however, the nature of this support is restricted by distance. The support is primarily emotional, gained from visits or over the phone, with their daughter being the main person they speak to if a problem or crisis arises. They are able to provide some support at a distance which supports Baldassar's (2007) research showing that care does not require geographical proximity. Their daughters did however visit Spain frequently thereby indicating the importance of personal contact.

Only daughters were involved in the care and support of Isolates (as was the case for the majority of respondents) which supports the idea that informal care for elderly parents tends to be undertaken by daughters (Ackers, 2004; Willyard *et al.*, 2008). However, most Isolates did not have sons and therefore it is not possible to know what care and support would have been provided by sons living in either Spain or the UK. An area of future research could include migration decisions based around care provided by sons rather than daughters. Only one Isolate (Sheila) had a son, however she was no longer in contact with him following a family argument.

### *Friendships and Social Activities*

Isolate participants had few or no friends and most did not take part in social activities. They were therefore unable to draw on friendships for support or help in response to a crisis or difficulty. Whilst most Isolates had maintained friendships when they were in good health, friendships declined as they became older, frailer and less mobile. This supports research which suggests that as people reach extreme old age and their health declines, opportunities for generating and servicing friendship are limited (Allan, 1989). This appears to be more difficult when living abroad as existing friends are left behind and during old age, fewer opportunities arise to make new friends. Those who moved for care were significantly less likely to have made friends in Spain, as their health and mobility was poor even at the time of moving which enabled few opportunities to meet people. Friendships and engagement in social activities also declined as friends became infirm or died, or financial constraints or caring responsibilities caused contact with friends to cease:

[Barbara] has got a friend in England so I am hoping maybe she can visit some time, but she is old and has got problems. (Daughter of Barbara, 93, Widowed)

I have lost quite a few friends over this [caring for her husband], because I couldn't go out really and share lunch, because I had to stay in and look after him.  
(Wilma, 76, Widowed)

This suggests that activity patterns become more restricted to the home during old age. As suggested by Droogleevers Fortuijn *et al.* (2006), people do not disengage from activity involvement overall; however, they disengage from specific activities during late adulthood, with daily life becoming more focused on the home and local environment in the later stages of old age. They found that being active in old age is important in the development of social capital, in particular maintaining links with the wider community; something which the Isolates did not do. For the Isolates, activity patterns tended to decline due to physical or financial restrictions, including poor health/mobility or friends/partners dying or becoming infirm. This therefore indicates a forced decline in social activities. Furthermore, there is evidence that social networks for the Isolates have become more confined to the local environment, with many participants' only support being from family members living close by. For those who do not have family nearby, there is a reliance on family to visit rather than the Isolates returning to the UK, again indicating a confinement to their home environment.

Whilst the Isolates had few friends, the last social ties to decline were with neighbours. Research shows that as older people become more neighbourhood bound, neighbours can be important links to community services (Regnier, 1980) and can provide care and support (Abrams, 2006). Some Isolates did receive practical help from neighbours such as with shopping and transport, as well as in the provision of information on local events and services:

Barbara next door she is very helpful if there is anything I need to know. (Elsa, 78, Widowed)

I have a Spanish neighbour and she helps me with any problems...she does a lot for me. (Gabrielle, 89, Widowed)

Those who received help from neighbours did not have the support of family living locally, so as found by Gabriel and Bowling (2004) neighbours can be important replacements for family living nearby.

### *Formal Support*

The support networks of the Isolates are indicative of Wenger's (1997) *private restricted support networks*, whereby informal support is limited and instead reliance is on formal support services. For example, most Isolates received a significant amount of emotional and/or financial support from Age Concern España. This includes Barbara who following a request from her daughter, is being repatriated by Age Concern:

I got in touch with [Age Concern] and as I say [volunteer] has done it all. I asked them what could be done. I didn't suggest that. It was Age Concern that suggested repatriation. I said I didn't know that could be done. It's in their hands really. (Daughter of Barbara, 93, Widowed)

Due to their vulnerability, the Isolates were in need of additional formal support. This was however restricted by living in Spain, either due to the limited availability of services or an inability to access them as a result of language and cultural barriers. Consequently, Age Concern often replaced other forms of both formal and/or informal support. For example, rather than turning to statutory authorities for help, Barbara and her daughter contacted Age Concern. Another example is Elsa, who turned to Age Concern for emotional and financial support following her husband's death, as her daughter lived in the UK, so support was restricted by distance:

She has been so helpful this girl [Age Concern volunteer] she really has. I don't know what I would have done without her...every time I want something, and I have asked she has always come up with something, with a good answer. (Elsa, 78, Widowed)

Some Isolates had accessed other forms of formal assistance; however, rather than seeking the assistance themselves, it was usually generated by another person (such as their daughter). Two participants had received help from Spanish Social Services in such as way:

Gabrielle: I got from the Spanish authority, a panic button.

I: How did you get that?

Gabrielle: My dear good friend, my neighbour...She is Spanish.

My daughter, she is a Spanish teacher, she is English but she teaches Spanish. She went everywhere [for help with care] and the only offer that she got was this day centre. (Wilma, 76, Widowed)

Formal support is therefore important to the Isolates; however, access to services is limited by language and cultural barriers (access to health, care and welfare services is discussed further in the next two chapters). Their restricted social networks also mean that they may be unable to actively seek support themselves.

### ***5.1.3 Isolation***

#### *Social, Emotional and Physical Isolation*

Social isolation and loneliness are commonly experienced by Isolates due to their small social networks and limited involvement in any social activities. Social isolation is a commonly cited problem for older British people in Spain (Mullen, 1993; Holbrook, 2004) as a result of a lack of meaningful relationships and social integration (van Baarsen *et al.*, 2001). This can be seen with Barbara who is largely confined to her home and the only people she sees are her daughter and a cleaner/carer for three hours per week:

[Cleaner/carer] is the only care she gets. I pop in obviously, or she has a meal downstairs or I take her to my house. But other than that she just sits in here and can't move. (Daughter of Barbara, 93, Widowed)

For those with no family close by, loneliness was even more common, as highlighted by Elsa and Sheila who live alone:

Sometimes I might drop in [restaurant/bar] for a coffee, I might have a full dinner sometimes. Not very often, I feel so you know, when I am down there I am on my own I might as well stay in my own home. (Elsa, 78, Widowed)

I am alone...I don't do anything really. I take the dogs out, I mean I have had [dog] now nearly 14 years, so all my going out is for [dog] really. (Sheila, 74, Widowed)

Emotional isolation is often caused as a result of bereavement (van Baarsen *et al.*, 2001) so was especially common among the widowed participants. Most missed the company and support provided by their spouse, from the support provided during difficult times to the day-to-day companionship, as Wilma describes:

I miss him [husband] a lot. We used to watch tennis together, but I don't like it any more. Can't watch it. We used to argue all the time, we both had players we like. Now I will put it on and I have no-one to say, see. (Wilma, 76, Widowed)

Physical isolation also occurred for those who lived in an isolated area situated away from friends and family or places to go out, shop etc. This compounded social isolation:

The thing is you see, it's where the place [her property] is situated here, it's very isolated where I am now. (Elsa, 78, Widowed)



There are no amenities close by and there is no bus stop...Even though they are able to hire a wheelchair, the area is so hilly that they could not push it...they want to maintain independence, but they need help and have to be dependent on me. (Daughter of Lauren and Steven, 93/87, Married)

Holbrook (2004) found that living in a quiet, remote area can cause extreme isolation especially for older people and those who cannot drive. Therefore, car ownership and access to public transport can be essential (discussed further in Section 6.1.1). However, whilst some Isolates were physically isolated from family and friends, they all relied on the telephone as a means of maintaining contact with people, as well as seeking help. This included practical help such as with shopping, as demonstrated by Elsa:

I phone up the [supermarket] manager and ask him to get me a few bits and pieces and he will bring them round for me. (Elsa, 78, Widowed)

The telephone was therefore used to overcome the difficulties associated with physical isolation, as well as to reduce social isolation.

### *Isolation from the Spanish Community*

Isolation and loneliness can be more profound when living abroad due to language barriers and a lack of integration into the host country (Huber and O'Reilly, 2004; Mullen, 1994) and this was the case for the Isolates who did not speak Spanish or mix with the Spanish community. This group had been living in Spain for an average of nearly 17 years so would be expected to be the most integrated and speak the most Spanish (King *et al.*, 2000). However, they were actually the least integrated group, with most (6 out of 8 participants) speaking very little or no Spanish at all, and having no interest in the Spanish culture or people. Some Isolates were able to draw on their small social network for help with interpreting to overcome language barriers:

She [Barbara] doesn't speak a word. I have always been there to translate.  
(Daughter of Barbara, 93, Widowed)

She would ring me up and say I have got a letter in Spanish and I don't know what it is all about. (Age Concern volunteer speaking about Elsa)

However, others did not have such support and were therefore forced to pay translators when speaking to a Spanish person. Some argued that their poor health and mobility limited their ability to learn Spanish and integrate; however, most felt that as they lived on urbanisations inhabited by other British people, there was no need to learn Spanish:

If we had come to Spain and had moved further inland you would have had to learn the language, but coming here everybody around you is English and of course when they speak in your language, they are the ones you have got to talk to. If we had moved inland we would have had to learn to be friends with Spanish people. (Elsa, 78, Widowed)

An inability to speak Spanish or desire to mix with Spanish people often increased isolation and reduced the support available to the Isolates, especially from the Spanish community and Spanish support services.

### *Isolation from the UK*

Whilst some Isolates had family living in the UK, they returned to the UK very rarely if ever:

I have been back 3 times since I have been here. In 18 years. (Elsa, 78, Widowed)

I haven't been to England since I last went with the kids, which I suppose was 10 years ago. We used to go every year. (Wilma, 76, Widowed)

The main reason for not returning was because they were physically or financially unable to do so:

I don't want to fly. I don't want to go anyway. All the hassle at the airport. Once or twice I get someone from the family come. (Gabrielle, 89, Widowed)

My sister, I ring quite often, but she's 82, she's not very well. If I go and see her, you know...I might as well stay here to be perfectly. She can't get out and around or anything you know. To me, I'd like to see her but it costs me a lot of money. She is in the UK. (Elsa, 78, Widowed)

There is therefore evidence here that maintaining relationships over a distance (especially through visiting) can depend on resources, particularly financial resources (O'Reilly, 2007), as well as physical (health) resources. Duval (2006) found that some migrants are constrained from transnational participation by being financially or physically incapable of travelling and this is the case for some Isolates. However, as the above quote from Elsa demonstrates, it was possible to maintain ties with family living in the UK through telephone calls. Whilst the Isolates did not use ICTs such as email, this does further demonstrate the importance of communication technology, especially the telephone, in maintaining social ties and generating support from a distance (Selwyn *et al.*, 2003):

My brother and my niece. I am in great contact with them, they phone me a lot and they come and visit us. (Wilma, 76, Widowed)

Conversely, whilst they rarely visit the UK, six out of the eight Isolates would like to move back to the UK to live. This was considerably more likely for those who moved for care, as three (Barbara, Lauren and Steven) are returning in the very near future for state-funded care. Another Isolate who moved for care is Harry; however, after living with his

daughter in Spain for some time, he is now living in a Spanish nursing home, which he “hates” due to cultural and language barriers and is desperate to return to the UK:

I wish I had been in a nursing home in England. It would be better than this. I could speak the language, I would have someone to talk to. I have nobody to talk to here, I talk to myself. [English roommate] he doesn't understand a word. (Harry, 86, Widowed)

Harry is however constrained from returning to the UK as his daughter wants him to stay in Spain and he is physically (and financially) unable to return without the support of his daughter. Elsa has also found that financial constraints are also forcing her to remain in Spain, despite a desire to return:

I wouldn't be able to afford to go back. And certainly not into where I want to go because they are very, very expensive, very expensive, so I am afraid I will have to spend my last years here. (Elsa, 78, Widowed)

### *Are the Isolates Transnational?*

The Isolates are not “transnational” in the traditional sense that they “belong to two or more societies at the same time” (Vertovec, 2005:1) and consider both as “home” (O'Reilly, 2007). In reality, most Isolates neither belong in Spain nor the UK. All Isolates identify themselves as British and maintain strong emotional links with the UK despite living in Spain. This has resulted in feelings of being disconnected and isolated and of not belonging anywhere. This is especially the case for those who moved out of necessity, as most did not want to live in Spain, moving only for care. As a result, they did not integrate or embrace the Spanish lifestyle and instead their social networks were confined to their family with whom they lived. For Barbara, Lauren and Steven, this has led to repatriation; whilst for Harry and Elsa, a strong desire to return to the UK but an inability to do so.

#### ***5.1.4 Vulnerability and Quality of Life***

Vulnerability and a poor quality of life were salient themes of this group; more so than any other type (which as mentioned above arises in part due to their old age and therefore poorer health). When looking at the key quality of life indicators of good social relationships, good home and neighbourhood social capital, positive psychological wellbeing and outlook, social activities/hobbies, good health, being financially secure and independent (Gabriel and Bowling, 2004), the Isolates are constrained in each of these areas. Social networks were limited and social activities (both personal and community activities) were rarely undertaken. All except one participant had experienced financial problems (usually as a result of care needs) and they had all experienced severe health problems often leaving them immobile and frail thereby increasing their dependence on others:

Her head is perfectly ok, she is just you know, can't basically look after herself... she is immobile practically. A very bad hip problem and she is deaf and only has one eye. She just cannot walk without a walker. She is too old to have a hip operation. (Daughter of Barbara, 93, Widowed)

When I dress myself it takes me about half an hour to be able to walk out here, I can't do much. (Wilma, 76, Widowed)

With an average age of nearly 85 years the Isolates are in the 'Fourth Age' when health problems and frailty are prominent. However, other respondents in this study are of the same age or older, yet are not as vulnerable and have a better quality of life. The extreme vulnerability of the Isolates is therefore largely due to a lack of social support, from both the British and Spanish communities, meaning they are less able to cope with the challenges that they face.

## 5.2 The Enclaves

In the bottom right quadrant of *Fig. 5.1* are the weakly regulated but strongly integrated “Enclaves” (Douglas, 2005). They have large social networks and strong ties; however, these networks are restricted to those with similar characteristics to themselves and with whom they share a common identity and fate (Hardill *et al.*, 2007). As such, they only mix with other British people and seek help and support from within the British community. In a similar fashion to the Isolates, they are inward looking and their lives do not encompass diverse groups. As a result, they do not mix with or seek support from the Spanish community. Due to their shared group life, they tend to reject external rules and regulations and instead regulate themselves through informal mechanisms. This has led to self-imposed constraints due to a limited access to formal support mechanisms, especially those provided by the Spanish community. Common characteristics of the Enclaves are good friendships, independence, a lack of integration and strong links with the UK, each of which will be looked at in more detail in this section.

The key characteristics of the Enclaves are shown in *Fig. 5.4*. The age of the Enclaves ranged from 68 to 83 years with the average being 73.6 years. Most are therefore in or approaching the “Fourth Age” (Laslett, 1991), however three are under the age of 70 and therefore are overall a younger group than the Isolates. As a result, whilst health and financial problems are a prominent issue which make them vulnerable, these are in most cases less severe than the Isolates and the need for care is less (resulting in less financial strain). They are however more able to cope with the challenges they face as they have better social support and whilst this may be limited to within the British community, it is used effectively to reduce vulnerability.

Five lived in the Torrevieja area and one in the Estepona area. All Enclave respondents lived in Spain all year round, except Rachael who spent approximately nine months of the year in Spain. They had spent an average of 9 years living in Spain, however this ranged from 4 to 21 years, with the majority (5 out of 6) living there for six years or less. The

Enclave types were fairly diverse and their social networks varied. Only half of the interviewed households had close family living in the UK, with the other half having no family at all. All Enclaves had good friends in Spain and half had friends in the UK. However, one key similarity between the Enclaves was that their social networks comprised only other British people, and any help and support they received came only from within or through the British community. Furthermore, in contrast to the Isolates, their friends are the main source of support and family is rarely relied upon.

**Fig. 5.4 – Key Characteristics of the Enclaves**

	<b>Years in Spain</b>	<b>Residence</b>	<b>Reason for Moving to Spain</b>	<b>Family</b>	<b>Friends</b>	<b>Nature of Age Concern Support</b>	<b>Other sources of Support</b>
Rachael (68) Widowed before moving	6 years	Lives on her own in a large flat on an urbanisation	To improve her health through the better climate.	Close children and family in UK.	Four close friends and some acquaintances in Spain.	Help with bureaucracy problems.	None.
Mary and Roger (81) Married	4 years	Live in small rented house on an urbanisation.	For a better quality of life due to weather and lower living costs.	No close family. No children.	Close friends in Spain and the UK.	Organising repatriation to the UK.	None.
Richard and Victoria (69/67) Married	5 years	Live in house on an urbanisation.	Had a holiday home and started spending more time in Spain.	Close children and family in the UK.	Many good friends in Spain and the UK.	Contact for information.	‘Help’ for equipment, Contra Cancer for healthcare.
Elenor (83) Widowed after moving	2 years	Lives alone in small house on an urbanisation.	Cheaper living costs.	No close family. No children.	Has friends in Spain, including Age Concern volunteers.	Volunteers are her main ‘friends’ who provide her with ongoing practical and emotional support.	Tele-alarm from Red Cross. Cleaner from Social Services.



***Fig. 5.5 – Richard and Victoria***

The Experience of Richard and Victoria

Richard and Victoria are 69 and 67 years old and are a married couple. Before moving to Spain they had a small holiday home in the area, which they sold five years ago to buy their current house, which they now live in permanently. They live on an urbanisation inhabited primarily by other British people and whilst they are “friendly” with the Spanish, their friends and networks in Spain are made up only of other British people. They have a “big circle of friends” in Spain all of whom live in the local area, and they are members of various British social clubs. They have some friends and close family in the UK whom they visit regularly. Victoria had a stroke a few years ago, and they have accessed a number of British charities for information and equipment hire including Age Concern, Help and Contra Cancer, but have never thought about approaching Spanish sources of support as they speak only a “few words” of Spanish. They regularly turn to their friends in Spain for support, as well as their children in the UK. However, whilst they are close to their children, they do not rely on them, instead seeking support from friends in Spain.

***5.2.1 Friendships: A Key Source of Support***

Although two Enclave households have close family in the UK (mainly children) whom they regularly visit and maintain close contact with, they do not rely on them for support or care as the Isolates do and are not dependent upon them:

I wouldn't dream of asking my children for a penny. I'd never asked my children because they are generous as it is...I have got my pride as well. I have managed so far so good. I wouldn't ask them for a penny. Mind you I am sure they would if I asked them. (Rachael, 68, Widowed)

Friends instead are very important for the Enclaves and will frequently turn to them for support. Some consider friends to be as important if not more important than family, especially for those without children. Some even considered friends to be close family:

[Friend in UK] you see, I have known her for over 30 years and she's more like a sister or mother to me. (Mary, 81, Married)

Some therefore have complex networks with a blurring of the boundaries between given and chosen relationships (Pahl and Spencer, 2004). This was also evident when Rachael considered her sister to be one of her closet 'friends':

My second dearest friend, well the one that I am very close to now, is my sister. (Rachael, 68, Widowed)

When faced with a crisis or difficulty, friends were able to offer three main types of support; emotional, instrumental and informational (House and Kahn, 1985). Instrumental (practical) help from friends in Spain was especially common, as was emotional support. In contrast to the Isolates, whose relationships were often based on dependency (largely due to their old age and poor health), this support was reciprocal, highlighting equality in the relationships:

"They [British friends] come round and visit us and sometimes...they have cooked an extra soup or an extra dinner and she brings it round to us. And they take us out sometimes and now and again [friend] will have a BBQ and we are invited over to their place. (Roger, 81, Married)

I: Do your friends help you – like when you were in hospital?

Richard: They will come round and see if you need help.

Victoria: If we wanted help they would all be there for us, the same as we would be with them.

Friends were frequently approached for advice and information, including information on health services. This indicates the unofficial and informal nature of support, as instead of following the official rules and regulations, the Enclaves tended to turn to their British friends for advice indicating their strong group mentality:

I: Did you learn about [private health insurance scheme] from your friends?

Rachael: Yes. They told me, they said it's advisable to go into it because it's like an insurance policy you see.

A friend has told me to get checked out [health check]. (Rachael, 68, Widowed)

Three Enclaves had British friends in Spain before they moved. The information and support provided by them both encouraged them to move and helped them to settle in Spain:

They [friends] helped us so much to arrange the flights and put us on the plane and what not and arrange with the neighbour next door to see us in. (Mary, 81, Married)

This is evidence of strong social capital, as social networks are being mobilised to provide benefits (Bourdieu, 1986; Anthias, 2007), which includes knowledge and information, as well as actual support. However, this is an example of bonding social capital as it is contained within a homogenous group i.e. British people and has been found to exclude (Putnam, 2000). For the Enclaves, exclusion is of the Spanish community and lifestyle.

### ***5.2.2 Maintaining Independence***

Whilst all Enclaves turned to friends for support, there was a determined effort to maintain independence, especially when faced with financial or physical crises:

I: Do [your friends in Spain] help you with your shopping and thing like that?

Mary: Well they would do if I asked her, but unless it's absolutely necessary I don't because I don't like to burden them with our problems if you know what I mean.

Roger: We are really independent from that point of view.

There was therefore a strong sense of independence among the Enclaves. Although most were experiencing health and/or financial challenges, they were not isolated or lonely mainly due to their desire (and ability) to go out and socialise:

I'm not lonely or miserable or anything because I have got a lot of friends, but sometimes it seems empty. I am not miserable in myself. Sometimes I get a bit perhaps depressed but I shake it off because that's how I am. I try to get out to go to the Chinese with some of the ladies for the birthday (Elenor, 83, Widowed)

At 83 years old, Elenor shares similar health problems with the Isolates which make her very frail and unable to walk far. However, her attitude is very different to the Isolates in that she makes a determined effort to socialise and maintain relationships. This in turn means she is less lonely and less vulnerable, as she has more social support. This may reflect different personality traits with the Enclaves placing a greater importance on socialising and maintaining friendships than the Isolates do.

Friends in Spain are therefore a major source of help and support for the Enclaves, and O'Reilly (2000a) found that British migrants in Spain have an average of sixteen friends, which would be true for most Enclaves. A number of authors (e.g. O'Reilly, 2000a; Betty and Cahill, 1999) have also noted that most older British people living in Spain tend to associate primarily with other British people, and whilst the Enclaves liked Spanish people and tried to be friendly to them, they did not have any good Spanish friends:

We are friendly with some Spanish people but they are not friends (Richard, 69, Married)

I've always liked the Spanish people and they really are very, very nice most of them...when I come into contact with the Spanish people I make the effort, you must make the effort (Rachael, 68, Widowed)

O'Reilly (2000a) has suggested that British migrants may have Spanish acquaintances but they have few friends, and this would be supported here, as although most Enclaves do not openly dislike the Spanish, they would not choose them as friends as the above quote from Richard indicates. This may be largely linked to their lack of integration and language competency.

### ***5.2.3 Lack of Integration***

All Enclaves were very positive about Spain, considered it to be their home and most would choose to stay if they were able to. However, none of the participants could speak Spanish, with some speaking only a few sentences and others only a few words as the following replies to the question, "Do you speak any Spanish?" indicate:

Only thank you and no and things that are necessary, you know. Just prime words that you learn...if you are in trouble you just have to go along with a pen and pencil and draw it. (Roger, 81, Married)

Just words, we can get around a shop, or market or bar. I can say odd words to people but can't hold a conversation. If I am under stress, I can't even say one word, it all goes. (Richard, 69, Married)

The reason that they did not speak more Spanish was sometimes recognised to be due to their social networks being limited to other British people and there was therefore “no need” to learn the language:

My problem is that I mix with too many English people...I suppose really, I should go to Spanish lessons but I don't really feel the need at the moment.  
(Rachael, 68, Widowed)

The Enclaves were therefore the most likely to adopt an “enclave mentality” (Champion and King, 1993), as most lived on purpose built urbanisations, with English shops and bars etc. and as a result mixed only with other British people. Instead of embracing the Spanish way of life, they live within well developed British communities, which they use for information, advice and help. The Enclaves also use British social clubs and organised activities as a way in which to seek support and generate friendships:

Richard: You can see it in the papers, there are just pages and pages of clubs. I think if you have got a hobby you could do it here in Spain.

Victoria: We do Irish roll bowls, and we go to a slimming club on a Friday, all be it that it doesn't work very well. Its good any way, it's got a social side to it.

Richard: And then friends, social, always going out for dinner somewhere. Marvellous.

[Neighbour] is marvellous...She runs the bingo. She does it on a Sunday and we go down there on a Sunday night and she doesn't let us pay for the tickets (Mary, 81, Married)

Social clubs provide an opportunity to meet new people and develop social networks and avenues of support; however, as social clubs are generally established within and for the British community, this could be evidence that they are in fact a barrier to wider integration (Betty and Cahill, 1997). All Enclaves live on urbanisations inhabited primarily by other British people. Due to the nature of the Enclave's social ties and their

rejection of the Spanish community, most social activities undertaken by the Enclaves were confined to within this urbanisation environment:

Mary: We used to enjoy the [bar/restaurant] until it closed down because that was easy, it was just over the road.

Roger: ...a restaurant come bowling green and we can walk over there and we can have fish and chips, or a sandwich and chips and have a beer and we used to go and sit over there and that puts you amongst people.

This is further evidence of bonding social capital, as social ties are limited to within the local environment with social networks containing little diversity. This restricts the type of support that they receive.

### *Integration and Accessing Formal Support*

All Enclaves had used British charities for support when faced with a crisis, including Age Concern España. Some had received ongoing support from the charity, especially for bureaucracy difficulties. Through Age Concern Elenor had accessed Spanish-based services, including a tele-alarm from the Spanish Red Cross and a cleaner/carer from Social Services. She however was not involved in organising them as when asked about the tele-alarm she was not sure where it had come from:

I: Is that [tele-alarm] through the Red Cross in Spain?

Elenor: Yes, I don't know. I suppose it is.

Therefore, whilst this support was from within the Spanish community, it had been organised by Age Concern (a British based source of support) showing that for the Enclaves (as with the Isolates), help-seeking behaviour originates from within the British community. Richard and Victoria had used other British voluntary organisations for support following her stroke; however, they had not ventured outside of the British

community for help and as a result felt that there was a lack of information. This was shown when she was talking about health check-ups:

What do you do if there is something wrong, where do you go? Who do you speak to? You would speak to your doctor I suppose. I am trying to get a mammogram and I can't get one, so I have got to go private now... So information, we can't find out why, we couldn't find out why...in England, if you had a problem, like a mammogram, this smear test, it was so easy to get, but they are not here and there are others things as well aren't there (Victoria, 67, Married)

This would suggest that the Enclave's lack of integration has, for some, led to insufficient information, causing them to struggle with local bureaucracy, and with accessing healthcare and Spanish services (discussed further in Chapter Six).

#### ***5.2.4 Maintaining Strong Links with the UK***

With the exception of Elenor, all Enclaves maintained strong ties with people living in the UK, which included visiting or telephoning friends and/or family. All Enclaves also retained strong emotional ties, considered themselves to be British and most felt that they would return to live in the UK one day. They therefore live a flexible lifestyle that encompasses elements of both Spain and the UK:

I think at some point I will have to go back to the UK but I knew that when I came here. But if we get some really nice weather and this arthritis eases up and I am able to do a bit more and I think I will leave it until next year...I have put myself on trial to see if I am any better here in Spain than I was in England (Rachael, 68, Widowed)



The immediate future, as things are, we will stay but if things get really worse and we can't find help if you need help, then we will go back (Victoria, 67, Married)

The maintenance of strong ties in the UK and Spain is evidence that the Enclaves do have 'split networks' (Pahl and Spencer, 2004), as networks are maintained in both countries. Therefore, whilst support networks in Spain are largely confined to the local environment, they are also maintained across national boundaries. Identities are also strongly linked with the UK, largely due to ongoing contact through social networks and a desire to return one day. They have maintained a strong collective British identity and have an emotional and physical attachment to the UK, thereby making them part of a Diaspora (Cohen, 1997). O'Reilly's (2000a:159) argument that British migrants in Spain could be classed as a sort of Diaspora as they "...retain a strong dependence on their home society" is supported here. This can be seen both emotionally and socially. They therefore generate support from both countries.

The Enclaves therefore live flexible lifestyles between Spain and the UK, so could be classed as 'transmigrants', as they are individuals who construct fluid and flexible migration trajectories, maintain ties across national borders, and maintain both as home (O'Reilly, 2007). The majority of Enclaves do consider Spain to be their home; however, most assert that they are very likely to return to the UK in the future and retain the facilities to do so. They do not like to be a burden on their family and therefore a return move would usually be to access state funded care if the need arises as the previous and following quotes from Victoria suggest:

I think if I was taken ill I thought I would have to go back home. (Victoria, 67, Married)

Their rejection of the Spanish community therefore limits their ability to cope with health problems in Spain. Whilst most are able to cope effectively with their health problems in Spain through utilising their support networks, many feel that they may have to return to the UK in the future to access more formal care.

### 5.3 The Individualists

In the bottom left quadrant of *Fig. 5.1* are the weakly integrated and weakly regulated “Individualists” (Douglas, 2005). Whilst the Individualists have few close ties with people, they do have many ‘contacts’ and acquaintances that are used instrumentally to promote individual success. Social ties encompass people across different social groups, including Spanish and British people, which are utilised to seek information and support when required. The key themes of diversity of social ties, instrumental help-seeking behaviour and integration are explored below.

The key characteristics of the Individualists are shown in *Fig. 5.6*. Their average age was 78.7 years, with four of the six being 80 years or over. They are therefore an older group than the Enclaves and therefore subject to health problems and frailty as a result of their old age. Two lived in the Torrevieja area, one in the Estepona area and three in Mallorca. They all lived in Spain permanently, and all except one had spent some time living and/or working in Spain before moving. They had spent an average of 19 years living in Spain; however, this ranged from 4 to 30 years, with the majority (5 out of 6) living in Spain for 18 years or more.

The Individualists have diverse social networks, with most having the informal support of family and friends in Spain and the UK, as well as access to formal support from Age Concern and other organisations. There was however, very little reliance on others for support and instead they tended to be very independent and self-focused, seeking help from the most appropriate source only when it was required and in response to specific needs. Whilst they have a lot in common with the Enclaves, such as their high level of independence and large number of people upon whom they can draw support and help, the Individualists have more diverse networks, fewer close friends and stronger links with Spain. They also have fewer links with the UK and no desire to return permanently. Whilst the Individualists (like all of the participants) have faced a number of challenges including health and financial problems, they are able to deal with their problems more effectively than any other group through the mobilisation of their social networks. This

therefore makes them less vulnerable, as whilst they encounter similar challenges to other people of their age, they are able to effectively use their social networks to protect themselves. They are able to employ effective coping strategies and have the ability to manage their own problems, as shown in the experience of Robin in *Fig. 5.7*.

**Fig. 5.6 – Key Characteristics of the Individualists**

	<b>Time in Spain</b>	<b>Residence</b>	<b>Reason for Moving to Spain</b>	<b>Family</b>	<b>Friends</b>	<b>Nature of Age Concern Support</b>	<b>Other sources of Support</b>
Donald (80) Single	18 years	Lives alone in rented apartment on small urbanisation.	Better climate. Spent some time travelling around Spain before settling.	No family except Godchildren in the UK.	Some British and Spanish friends in Spain and the UK.	Use for translating, transport and information.	Member of British run social club in Spain.
Celia (90) Divorced before moving	30 years	Lives alone in flat near Palma (capital city).	Lived in Mallorca before. Has friends there.	One close son and some family in the UK.	Some British and Spanish friends in Spain and the UK.	Use for information.	Uses British Residents Association for information and support.
Robin (62) Married	4 years	Lives with wife in a rented flat.	To use Spanish health services. He has worked in Spain before.	One son and some family in the UK but limited contact.	British/American friends all over the world, Spanish friends.	Use for financial support and information.	Spanish Town Hall for information and support. Member of Masonic Lodge.
Andrew and Shirley (81/87) Married	20 years	Live in house on an urbanisation.	Had a holiday home before moving. Moved for better climate and golf.	Four close daughters in the UK.	Some British and Spanish friends in Spain and the UK.	For information and access to care.	‘Help’ for care. Members of Golf Club and Spanish Pensionista club. Town Hall for information.
Robert (72) Divorced before moving	22 years	Lives alone in a small apartment.	Moved after divorce. Had spent some time in Mallorca before moving.	Some contact with son and family in the UK.	Few friends in Spain and the UK – retains little contact with them.	Organised financial support.	None

***Fig. 5.7 - Robin***

The Experience of Robin

Robin is 62 years old and lives with his wife in a rented apartment in an area inhabited by both British and Spanish people. Before moving to Spain permanently four years ago, he lived all over the world whilst working for the Royal Marines and then spent many years working across Spain during the 1980's and 1990's for a British company. As a result, he has paid tax and insurance contributions in Spain. He has a number of health problems which restricts his mobility, including diabetes, arthritis and spinal injuries he obtained whilst in the Marines. He is now unable to work and as a result, he has considerable financial difficulties. He had been waiting for an operation in the UK for many years and decided to move to Spain to use the Spanish health service so subsequently became a resident and had his operations in Spain. Robin speaks fluent Spanish and is well integrated, mixing with the Spanish regularly. He has a few close friends; however, he has many acquaintance type relationships with British people in Spain and the UK, Spanish people and local authorities/organisations in Spain. Whilst he has faced some considerable health and financial challenges that make him vulnerable, he is able to use these social ties to secure advantages and cope effectively, including to gain access to UK benefits and healthcare. Robin is discussed in more detail below.

***5.3.1 Diverse Social Ties***

*Family, Friends and Acquaintances*

Family members were mentioned very rarely by the Individualists, particularly as some have no close family and for the others, contact with family in the UK is limited to occasional visits. This is the case for Robin who has a son and two Aunts in the UK whom he rarely sees. There is therefore little ongoing support available from family members; however, links with family are maintained and most Individualists felt that

family would provide support if a crisis arises. This is shown by Robert who sees his son only occasionally but feels he would provide support if he was in difficulty:

I have got a son and grandchildren in England and I know they wouldn't let anything happen to me. (Robert, 72, Divorced)

Friends are more important to the Individualists and are mentioned frequently. Whilst the Individualists do not have an abundance of close friends as the Enclaves do, they have many acquaintance type relationships. Robin has a few good friends and many acquaintances who live all over the world, including in the UK, Spain, Canada and America. He is a member of the Masons and has developed friendships with fellow members in both the UK and Spain with whom he stays in contact and can turn to for support if he needs to:

I am a Mason, and there is a few guys in the lodge who I turn to, who help, in Spain. I belong to a lodge in [UK] as well, so they are the main friends. (Robin, 62, Married)

Social ties and contacts are frequently used for instrumental purposes as indicated by Robin who maintains contact with his GP in the UK to retain informal links with the UK health system (although he is not legally entitled to use the British NHS):

I am still registered with my GP as well. I email him all my treatment I get here. I either fax it or email it to him so he is up to date with what I am getting here. (Robin, 62, Married)

Robin also has links with a British MP who is helping him in his appeal to access UK disability benefits:

I got onto this high guy, this guy who works in Derbyshire and he's an MP and he's sticking up for me and saying I'm perfectly right, we are part of the European Community. (Robin, 62, Married)

Therefore, despite having quite severe health and financial challenges that make him vulnerable, he is able to successfully cope with those challenges through the utilisation of his social networks thereby making him less vulnerable. Similarly, Donald who is almost blind, has made friends with members of the local police force in Spain from whom he accesses local information and support:

I have made quite a lot of friends in Spain, particularly Guardia Civil strangely enough, that's the police force. A police officer and his wife lived across the road, I got to know them and they introduced me to many of their fellow officers. (Donald, 80, Single)

For the Individualists, social networks are therefore very diverse, encompassing a wide range of people and can be used instrumentally (both formally and informally) when help is needed. This is evidence of strong bridging social capital, which encompasses people across diverse social cleavages (Putnam, 2000) and is important for links to information and support. The diversity of friendships and acquaintance type relationships means that there is always an appropriate person to turn to in every situation. For Donald, this also includes support from the manager of his apartments whom he uses to access medical help. He also receives help from local people including shop keepers and bus drivers with everyday activities that he cannot do due to his blindness. Therefore, rather than being confined to the home as an Isolate might do, he is able to go out and retain a reasonable quality of life despite his significant disability and old age. He also has friends who cook for him and who help with any bureaucracy problems:

[Friends and other local people such as the butcher] helps me across the road.  
[Friend] made a white stick for me (Donald, 80, Single)

I went down to friends of mine and I told them about it [problem with his pension] so I put my papers over to them and they sorted it out for me (Donald)

Most Individualists have Spanish friends and one of the key differences between the Individualists and Enclaves, is that the Individualists prefer to mix with Spanish and other non-British people rather than with other English people. This includes Robin who says that in Spain “99% of my friends are Spanish.”

As with the Enclaves, there is some evidence of a blurring of boundaries between family and friends, highlighting the flexibility of social networks:

We have got a very good couple of friends of ours, they call us mum and dad. They are very good. They come and take us out. We went to their house yesterday for a barbeque (Andrew, 81, Married)

### *Using ICT*

The Individualists were able to maintain regular contact with their friends and family in Spain and across the world by visiting, as well as over the telephone:

We phone [daughters] regular and they come out here. Two of them in England have been out at least twice this year (Andrew, 81, Married)

I see my niece, she comes and stays here sometimes, and my son comes sometimes but I go at least once a year to London. I don't stay with them, I stay with friends (Celia, 90, Divorced)

We [friends in Spain] phone each other regularly. We get free phone calls because we have a got a computer, so it's free. (Robin, 62, Married)



As shown by the above quote of Robin, the Individualists also made use of computers and email; something that neither the Isolates nor Enclaves did. Robert has recently bought a computer so that he can use email to stay in touch with friends and family in the UK. Robin also uses email regularly to stay in touch with friends in the UK, as well as for more instrumental purposes, including to contact his GP in the UK and to contact Age Concern:

My friends in Derbyshire in the lodge, we send emails to keep in touch...not every day but every couple of months (Robin, 62, Married)

[Age Concern volunteer] is always on the email, do you need anything? (Robin)

Some Individualists were therefore able to maintain transnational ties through the use of ICTs (O'Reilly, 2007; Selwyn et. al. 2003). However, despite research suggesting a high use of ICTs among older British people in Spain (O'Reilly, 2007), it was fairly limited and as the following quote from Robin indicates, some older people do not like to use modern ICTs instead preferring to maintain contact using more traditional communication methods such as letter writing:

[Friend in Canada] writes to me. He hates computers so when I contact him I have to write him a letter. (Robin, 62, Married)

Nonetheless, there does appear to be some use of ICTs, in addition to the telephone, among the older British community in Spain. This however is most prominent among the Individualists who use ICTs to create and maintain social networks, as well as to generate support. This is indicative of their instrumental help-seeking behaviour.

### *Seeking Support*

Most Individualists are members of British social clubs; however, they only use them for instrumental purposes to seek information and support when required:

Celia: I am not a clubby sort of person. I am a member of ESRA, the English Speaking Residents Association. I go to their lunches or whatever. I am not a member of any other clubs.

I: What is the main reason you are a member of ESRA?

Celia: It's very helpful for people, I would recommend anybody coming here to join ESRA. They tell us what is going to happen next week. It is very good

All Individualists had also used Age Concern España; however, for most, contact was quite limited and only used for information. Whilst Robin and Robert used Age Concern for financial support, they did not rely on them and instead sought help and support from a vast range of sources. This included using local Spanish services and local authorities for information, financial support and social care:

You get stuff from the Town Hall... I have just found out that I am entitled now, I can go to Calvia town hall, because we are so skint, we can get subsidised housing....[The information] is there, but you have got to find it, you have got to ask. (Robin, 62, Married)

This is in sharp contrast to the Isolates who relied solely on Age Concern España, rarely seeking support from elsewhere. Most Individualists instead preferred to mix with Spanish people, attend local events and receive information and support from local Spanish people.

### ***5.3.2 Instrumental Help-Seeking and Individualism***

The Individualists are instrumental in their approach to seeking help, as they have wide social networks (formal and informal) from whom they can draw support when it is required. Some are able to work the system to their advantage, as indicated by Robin who moved to use the Spanish health service yet stays in touch with his British doctor (by retaining an address with his sister-in-law in the UK). He even appeared on Spanish television to argue his case for his benefits to be reinstated. Despite wide social networks, the Individualists are very independent and possess strong individualist tendencies:

I don't like to impose myself on people like that. I can look after myself as I have done all my life (Donald, 80, Single)

They do not rely on any one person/group and instead liked to solve their own problems, only seeking help when it was really needed. This indicates their lack of constraint through formal regulation and procedures, and their individual-focused behaviour:

I don't involve my friends in my health problems. Age Concern know about it because they have very kindly given me medical care for starters, but I don't like to involve my friends in my health problems. They can see I have an eye sight problem and they help me...like with cooking a meal. But I don't say can you take me shopping or anything like that, I just get on and do the job (Donald, 80, Single)

Celia, despite being 90 years old, is also very independent and is very happy living on her own. She does not like to rely on others for support or company, choosing to eat out on her own frequently. She also returns to the UK most years during the summer to escape the high temperatures and has friends in the UK with whom she stays (so she does not have to pay for accommodation):

I try and go to England to get away from the heat, July and August particularly are very sultry and hot. Not to be recommended those months, if someone can get away so much better (Celia, 90, Divorced)

This again demonstrates how Celia is using her social networks instrumentally, allowing her a flexible lifestyle and independent living. This shows further evidence of strong social capital and the way in which it can be used to reduce vulnerability. On the other hand, a few Individualists have smaller social networks yet still possess individualistic qualities. The most prominent example of this is Robert, who has very few friends and seeks help only from Age Concern. For this reason he could be classed as an Isolate, yet he shows strong individualistic tendencies and has made a choice to be alone and independent:

I have become a bit of a recluse, a loner actually. I like it that way, I enjoy my own company (Robert, 72, Divorced)

He has also planned for his future by putting his name down on the list for a benevolent society nursing home in the UK should his health decline considerably, highlighting his instrumental help-seeking behaviour. It is this element of choice that makes him an Individualist.

### ***5.3.3 Integration***

Four out of the six Individualists speak fluent Spanish and are well integrated into the Spanish community, regularly mixing with Spanish people and using Spanish services. This includes Robin who speaks fluent Spanish, as well as some French and German and feels that all British people living in Spain should speak Spanish:

This is where a lot of the Brits and expats fall down. I know a one lady who had lived here 30 years and she can't speak a word and it's very silly. You have got to make the effort (Robin, 62, Married)

He was also very critical of British people who do not integrate, including those who join British social clubs:

A lot of the expats, they have their little clubs...that's all they do, they are right to do it but I am here [in Spain] and I am not there [in the UK] anymore. That doesn't appeal to me in any shape or form. I am not being snobbish, I used to go to a quiz in Palma in the winter every Wednesday and they do nothing but moan and whinge...Half the lot that's here are too busy playing cricket, going to quizzes, garden parties and thinking that they are in a colony. That's the problem (Robin, 62, Married)

This was echoed among other Individualists who were equally critical of British social clubs and those who do not integrate:

They have got this club, the Brit club they used to call it. It used to grind me down. Absolutely terrible...They are very clannish you know the British, terrible. They play bowls, they have got bowling clubs, about a dozen clubs, and they are all Brits, not a Swede, a Spanish or anybody amongst them and I say to them, how can you live like that? It's like living in a ghetto (Andrew, 81, Married)

This suggests that the Individualists like to separate themselves from the British enclave mentality that has been described by many authors (e.g. Champion and King, 1993) and are therefore very critical of the Enclave types discussed above. Whilst research suggests that most older British people living in Spain do not integrate or speak Spanish (e.g. O'Reilly, 2004; King *et al.*, 2000; Betty and Cahill, 1997), the Individualists show that this is not altogether true as they do choose to integrate and speak Spanish.

One of the reasons why the Individualists like to integrate into the Spanish community and lifestyle may be due to the fact that most have lived abroad, either in Spain or elsewhere before. This seems to give them a different attitude to most other respondents. This includes Robin who has lived and worked in Spain, and Celia who has lived all over the world, including Spain and both speak a number of languages. This is evidence of strong cultural capital, as gained through a good education, employment and language ability. By mobilising their cultural capital they have been able to develop strong ties to the Spanish. This makes them considerably less vulnerable and better placed to cope with crises when they arise, as they have good and instrumentally-selected sources of support.

Whilst the Individualists still identify themselves as British, they have maintained few emotional and social ties to the UK and do not express a desire to return as most Enclaves and Isolates do. This includes Robin, who has not been back to the UK for three years and does not intend to ever return permanently. Most would only return if they were forced to, such as the example of Robert who would only return if he was in need of care, and would use his contacts to do so. Only one Individualist, Shirley, expressed a desire to return to the UK to be close to her children should her husband die. Whilst Shirley has been classed as an Individualist, this is mainly through her husband, Andrew, who is a strong Individualist and makes the majority of household decisions. Shirley, on the other hand, is quite reliant on her husband and her children in the UK whom she remains very close to:

At the moment I don't have problems, I am lucky I have got a husband that...if I was on my own, I would want to sell up and go back to England to live (Shirley, 87, Married)

Therefore, she appears to be a hybrid type, on the border of an Individualist and an Isolate, with her individualistic tendencies being obtained through her husband.

## 5.4 Hierarchy

In the top right quadrant of *Fig. 5.1* are the strongly integrated and regulated “Hierarchy” types (6, 2004). This group have strong social ties with diverse groups meaning that support is plentiful. They have a commitment to formal rules and regulation so often seek help through formal organisations. The key themes of diverse social networks, integration, a transnational lifestyle and trust in experts are discussed.

The key characteristics of the Hierarchy types are detailed in *Fig. 5.8*. They are a highly diverse group with their ages ranging from 51 to 86 years (with the average being 72.4 years). Whilst the 51 year old respondent is only just beginning to enter ‘old age’ (when defined as being over the age of 50), she is included in this study as a vulnerable person due to the significant challenges she has faced (outlined below). The remainder of Hierarchy respondents are over 65 years old, with two being over the age of 80. Two participants lived in the Torrevieja area, two in Mallorca and one in Estepona. They all lived in Spain permanently. Two households had spent around seven years in Spain whilst the remaining two had lived there for over 15 years. All Hierarchy types had strong social networks, with a wide range of informal and formal ties. Both family and friends were important to them, as were social clubs, and links with formal organisations all of which provide support. This is highlighted in the case of Audrey in *Fig. 5.9*.

**Fig. 5.8 – Key Characteristics of the Hierarchy Types**

	<b>Time in Spain</b>	<b>Residence</b>	<b>Reason for Moving to Spain</b>	<b>Family</b>	<b>Friends</b>	<b>Nature of Age Concern Support</b>	<b>Other sources of Support</b>
Amy (51) Widowed after moving	7 years	Lives alone in a rented house owned by the bar she works in.	To improve her health through better climate. Has lived abroad most of her life.	Close daughter and family in the UK, including parents.	Friends in the UK. Close friends in Spain of all nationalities.	Financial support.	Links with SSAFA.
Audrey (66) Widowed after moving	6 years	Lives alone in a small house on urbanisation.	To improve the health of her terminally ill husband through the better climate.	Close daughter and grandchildren in the UK.	Friends in UK. Many close English and Spanish friends in Spain. Spanish boyfriend.	Use for information and equipment hire.	Has used a private doctor. Runs singles club.
Ida (79) Divorced	16 years	Lives alone in a house on an urbanisation near the town centre.	To improve her health through the better climate.	One close daughter in Spain and another in the UK.	Friends in UK. Close friends of all nationalities in Spain.	Use for social support. Attends centre and outings.	Runs gardening club. Used to run singles club.
Fred and Felicity (86/80) Married	19 years	Live in a rented house on a small urbanisation.	Used to come for holidays and had friends there.	Close to siblings in the UK.	Few friends in the UK. Some British and many Spanish friends in Spain.	Organising care, including nursing home.	Spanish neighbour cleans for them. British Consulate in Spain for advice.



***Fig. 5.9 –Audrey***

The Experience of Audrey

Audrey is a 66 year old widow who moved to Spain six years ago with her husband when he became terminally ill. They moved to improve his health through the climate and in doing so she believes that they “bought him another five years”. For five years she cared for her husband in Spain and following his death a year ago, has decided that she wants to remain in Spain. She still has some close friends and family in the UK, including a daughter, whom she visits and can rely on for support. She also has very good social networks in Spain, including a Spanish boyfriend and as such speaks almost fluent Spanish. Audrey lives in a small bungalow on an urbanisation, which is inhabited by many British people; however, she is well integrated into the Spanish community. Whilst her closest friends are English, she likes to mix with people from many different nationalities and has some close Spanish friends. She has a very active social life, which includes running a singles club. She has also used formal support services including Age Concern for information and private Spanish doctors for care. When she was caring for her husband and since his death, she has been able to draw upon her diverse social network for support.

***5.4.1 Diverse Social Networks***

*Family*

All Hierarchy types have strong family ties in the UK, which for most includes children and grandchildren, and for some siblings and parents. They maintain close relationships despite barriers of distance by speaking on the phone, writing letters and maintaining regular visits to and from family members. Some even maintain contact through the use of email, including Audrey who speaks to her grandson using Windows Live Messenger, highlighting the important role of ICTs in the maintenance of social ties:

I have got my grandson who I speak to on msn every week. (Audrey, 66, Widowed)

Support from family is readily available and varied, and includes practical and emotional support. For example, when Ida was ill, she was able to rely on her daughter to look after her:

My daughter had to feed me with a spoon because doing anything, just holding something, you know [was difficult] and I had to take an enormous amount of [medicine]  
(Ida, 79, Divorced)

Family contacts were also useful in providing links to more formal support. For instance, Amy's family (and family friends) in the UK were able to put her in touch with Age Concern:

My parents have a friend, who works for SSAFA [Soldiers, Sailors, Airmen and Families Association], and when my husband was really, really ill and my parents were worried because I was panicking about money and I didn't know what to do and I didn't know how to do all the paperwork. He contacted [Age Concern volunteer] and [volunteer] rang me up (Amy, 51, Widowed)

The Hierarchy participants, as well as their family and friends, were well connected to various networks, which they were able to utilise in the provision of support, indicating a high degree of social capital (Anthias, 2007).

### *Friends*

Participants were however, not reliant upon family for support as the Isolates were, as friends, employers and acquaintances were also able to provide help. This was demonstrated by Amy when she was experiencing financial problems following the death of her husband:

The Pension Service put a block on my account...Nobody told me, I just went to try and my card was snatched, I went to the bank and nobody would tell me. My boss rang up

and they wouldn't tell anybody anything. And my dad is ringing up and he was trying to find out... All I got told, through my boss who spoke fluent Spanish was that my account was blocked and it was to do with my pension... My best friend is with me, she keeps coming up and down, she speaks fluent Spanish but she has never been in this position (Amy, 51, Widowed)

Friends are therefore very important to the Hierarchy types and form a key element of their support. Networks of support are largely reciprocal as help and favours are provided in return:

I look after their animals, or I translate for some of them. Or I speak to people if I have got contacts that they need, things like that. I have put someone in contact with [Age Concern] as well (Amy, 51, Widowed)

Whilst they all have close British friends, they also have close Spanish friends and most have friends of other nationalities, including Germans and Swedes. They therefore like to mix with a variety of people. They all appear to make friends very easily and enjoy socialising, as indicated by two participants who run social clubs. Ida runs a gardening club and uses it as a key opportunity to socialise and meet new people:

Monday's the gardening club and we meet along there and then every other Monday we go out somewhere. I did have three of them here for lunch a couple of weeks ago (Ida, 79, Divorced)

They also take part in local events organised by both the Spanish and British communities. For Fred and Felicity this included being invited to Spanish weddings:

If someone has a birthday, the Mallorquians, not so much now but going back a couple of years, it was always in a restaurant and everything was free and everyone from the village that they know was invited. You find now, if there is a wedding, you are invited (Fred, 86, Married)

They have all received a great deal of support from friends, including emotional, practical and even financial help. For example, Audrey has a good relationship with both her British and Spanish neighbours and when she was taken into hospital, they were able to help, which included providing personal care for her husband:

[Husband] just sat in the chair and [neighbour] came over every morning and got him up... made sure he took tablets, see if he wanted anything for his breakfast. He would wash him and cream his legs for me. He did everything for me. Changed the beds. It was only three days, but it was every day (Audrey, 66, Widowed)

Fred and Felicity have many Spanish friends who support them, such as with preparing and delivering food, cleaning, shopping and taking them to the hospital. They are also friendly with the local bus driver who picks them up and drops them off from outside their house. Amy's Spanish friend/employer also offered her financial help in the form of very cheap accommodation:

She is only charging me 300 euros a month and that includes my food, and electric and water. I couldn't stay in the apartment I had, even though the landlord said he would reduce the price....[friend] said use the house. I don't use it, use it. It needs decorating and painting. She is getting that lad to do the outside...it needs rendering so he is going to do it for me (Amy, 51, Widowed)

#### ***5.4.2 Integration and Language***

Friends are therefore diverse and plentiful, and include Spanish and British people. However, in a similar manner to the Individualists they tend to reject the "enclave mentality" in favour of integration into the Spanish community and way of life:

I: Do you feel more part of the British or Spanish community in Spain?

Felicity: Spanish. There is a place called ESRA, the English Speaking Residents Association, but we didn't join it, because to us, they have their own ideas, and we come here to Spain so why go back to England, so we have always stayed with that. Also, an awful lot of them will only go in English restaurants, [husband] eats snails and that (Felicity, 80, Married)

We live in Spain so we can't expect everybody to speak English that's not fair. We chose to live here, they didn't choose for us to come, so yes, I mean it is essential that you learn some Spanish (Audrey, 66, Widowed)

The Hierarchy types were all very well integrated, had many Spanish friends and could speak Spanish. The decision to integrate and learn Spanish was usually made before moving to Spain, indicating a high degree of preparation:

You try hard, you come and spend months and do all the Spanish things you can do, to try and integrate yourself before making the decision, before you sell your house or mobile home as was in our case (Audrey, 66, Widowed)

Some had turned to the Spanish community or their Spanish friends for help learning Spanish, which proved to be very successful:

Fred: In Mallorca, 50% of the Spanish can't speak Mallorquian, so you have got to find out who they are and speak their language. We went to school when we first came and we got the basics.

Felicity: ...It was difficult. I think maybe with being older, I think if you learn your alphabet first, which I did with a few children in the village, and that's what I did.

I had a Spanish friend. I met her on the bus and she said something in French to me and because I used to speak French, and we got talking and I told her I ran a Solo's so she

came along and she taught me quite a lot of Spanish when we used to go for walks along the cliff at night (Ida, 79, Divorced)

Therefore despite the majority of research on older British people in Spain claiming that they do not integrate (O'Reilly, 2004; King *et al.*, 2000; Betty and Cahill, 1997), this is further evidence that in fact some do. Whilst Hierarchy participants generally do not have the high job status and education of the Individualists, they still have cultural capital, as gained through their attitudes, knowledge and experience of the Spanish lifestyle, including through their ability and willingness to speak Spanish. They have been able to mobilise their cultural capital to develop strong ties to the Spanish community and local services (see Section 5.4.4). They have used these ties effectively to generate help and support, which in turn makes them less vulnerable.

#### ***5.4.3 A Transnational Lifestyle***

The Hierarchy types had a strong emotional attachment to Spain, as they all felt part of the Spanish community and most felt that Spain was their home:

If someone said to me in England, are you going back to Mallorca and I would say I am going home. To me, Spain is my home (Felicity, 80, Married)

I: Why would you not go back to the UK?

Amy: I basically don't feel like I would fit in. I have lived so many years abroad in so many different countries, I don't feel English. I won't say that I would only live in Spain, it may be another country, but I would not go back to the UK.

I: Do you consider Spain to be your home?

Amy: Yes. I feel more Spanish than I do English.

However, they all also maintained strong links to the UK, and to a certain extent liked to take part in the British community in Spain. This includes Amy who, as can be seen from the above quote, feels more Spanish than English, yet maintains British ties:

Amy: I take part in [the Spanish culture]. I love the way of life.

I: Do you feel part of the Spanish community more than the British?

Amy: No. Its half and half.

Interestingly, it was often during times of crisis that people turned to the British community for help, particularly for formal support:

We need the [British] charities yes, we always need that because they provide a network of support and they do a lot out here. They have clubs and it's good for people to go to them. If you still want to retain that link, even if you do not want to live in the UK, you still want to maintain that Englishness. Discuss things that happen in the UK with other people. You want that. Sometimes friends that are English, particularly in times of stress or when you are grieving (Amy, 51, Widowed)

The Hierarchy types are therefore the most transnational group, as they maintain a collective British identity by having British friends and links to the UK, whilst living a full and integrated life in Spain. A transnational community exists when exchanges of resources or information, or visits take place with people in the homeland (Vertovec, 2005) and there is evidence of this here:

Then this [friend from Age Concern], she was going to England and she said do you want anything and I said do you mind getting me some of those heat pads, they are ever so good, so she brought me some back. I gave her the money and she wasn't going to take it but I insist on paying my way (Ida, 79, Divorced)

Whilst this is also true for other types, including the Enclaves, what makes the Hierarchy types truly transnational is their integration in Spain, as according to Vertovec (2005:1) "to be transnational means to belong to two or more societies at the same time". This is the case for the Hierarchy types as they 'belong' in Spain as demonstrated by their being part of the Spanish and British communities in Spain, and 'belong' in the UK as shown by their maintenance of strong ties to the UK, including regular visits. However, in contrast to the Enclaves, the Hierarchy

types are more likely to see Spain as their home, with four out of the five seeing Spain as their home and the place they want to remain for the rest of their lives.

#### ***5.4.4 Trust in Experts***

##### *Formal Support*

The Hierarchy participants have received a considerable amount of support from formal sources and organisations. Three of the four households received a substantive amount of help from Age Concern España with financial, care or social difficulties. Ida uses Age Concern for social support, as she goes to the Age Concern centre every week to meet people, goes on their outings etc. She finds this very beneficial and gives her access to information and social events:

The week before [volunteer] said there is going to be a concert at the [place], they are ever so good...used to be in the open air. Lots of my friends were in that then. So she said, it's the 31<sup>st</sup>... I will pick you up and bring you back. So I shall be going out that night (Ida, 79, Divorced)

Age Concern were able to secure Fred and Felicity a place in a Spanish nursing home, as well as provide financial support for Amy. Some have also accessed other formal support services, including Amy who used her social ties to acquire her mother-in-law care from a Hospice in Spain, which in turn resulted in a free nursing home place:

We were here two years and then [mother-in-law] became terminally ill and we went to the local Cudeca, which is a hospice, it's half English, half Spanish. It's a beautiful hospice. It is very famous down here. At the time they didn't have any beds. We went to them because I knew somebody that worked for them and they sorted her out and get her in a residential home. A lovely, beautiful place and we didn't have to pay a penny (Amy, 51, Widowed)



This highlights the importance of social ties in the generation of support. This is further evidence of strong bridging social capital, whereby social ties are utilised to seek advantage. Social ties were drawn upon for support in order to cope with health, care and financial crises and as such significantly reduce vulnerability. This can be seen with Fred and Felicity, and Amy who used their social networks to secure social care. This prevented the need to return to the UK as many Isolates are.

### *Preparing for the Future*

In the same way that many of the Hierarchy types were well prepared before moving to Spain, they also liked to plan for their future, which for Fred and Felicity involved securing social care. Ida is also taking steps to return to the UK, as health problems and a series of muggings have made her think about the future and she has realised that if she remains in Spain, she may end up very isolated:

I never go out at night unless someone takes me, so I am kind of like in a prison. Although I am old anyway, I have had my time and I shouldn't feel like this, but inside I am young...I am a very friendly person, a very honest person and I do make friends easily but when you are ill you can't be bothered, when you are in a lot of pain. (Ida, 79, Divorced)

She is therefore taking steps to prevent herself becoming an Isolate. The Hierarchy types are therefore very proactive in generating help and support and use their informal and formal support networks to assist them.

### *Regulation*

Whilst the Hierarchy types have diverse informal social networks which they regularly draw on for help and support, they also place trust in experts and institutions, and have a commitment to

formal rules and regulations. They all ‘liked to do things properly’ and for this reason were all legally resident in Spain. In the same way that they are critical of people who do not integrate and speak Spanish, they are also negative about those who do not follow Spanish regulations:

The only thing that I would say to anyone coming here, if you live by their rules...there are people that come here and they say I am not going to register, and we know a lot of people here who are not registered. But to us, we live in a foreign land, so therefore you go by their rules. That’s what we did. As soon as we found out that you have to have whatever, we just went and went through it all. But as I say it has always been Spanish. (Felicity, 80, Married)

Fred and Felicity also felt that it was important to register with the British Consulate as they like to follow the ‘official’ channels rather than rely solely on informal networks:

We tell many people who come here for the first time to go to the Consulate and register because if anyone wants to contact you and they don’t know where you are, they just get in touch with the Consulate. The RAF tried to contact me twice, and they had my number at the consul and the consul telephoned us. It is, it’s brilliant. (Fred, 86, Married)

Amy also felt that the British Consulate should play a greater role in supporting British people in Spain:

I think the Consulates should help out. I think the consulates should have someone based here to help them, help people know their rights, their benefits rights. I shouldn’t have had to go to [Age Concern volunteer]. I was lucky that my family, I would never have known about Age Concern otherwise. I think someone should be based in Malaga at the Consulate there. Have somewhere you can go and say right I am in this trouble that trouble, how do I go about it. (Amy, 51, Widowed)

There was therefore a common feeling amongst the Hierarchy types not to “break the rules”, particularly in terms of financial rights. This was the case for Amy when she was organising her

husband's financial affairs and approached Age Concern for help in determining the "rules and regulations":

It was all done through official, officially though a lady, it's all been done properly. I know [Age Concern volunteer] would never dream of getting me something that I couldn't have. (Amy, 51, Widowed)

This was also the case for Audrey who after spending time in both Spain and the UK, decided to register in Spain and lose her and her husband's disability benefits. Whilst she recognises that she could have lived in Spain and continued to receive her benefits, she felt that it would not be fair to break the rules:

We went back a few times because we still had hospital appointments so we did go back so we weren't breaking the rules. We were going back so that we weren't staying here for more than the allotted time. We were back and forth so as far as we were concerned we were not breaking the rules, so we were still getting money which paid for his medicine...He got so worse that he was in hospital so often that yes we were using our E111 at the time, and thought this is ridiculous, this is getting so...you are not using it properly, you are abusing it. So we have got to take out resedencia. So that's what we did. (Audrey, 66, Widowed)

The Hierarchy types therefore, whilst being highly integrated, are also highly regulated; however, this is out of choice rather than necessity due to a desire to 'do things properly'.

## **5.5 Summary**

The primary purpose of this chapter has been to address the second research aim, namely to examine the kinds of support networks that vulnerable, older British migrants construct and access in the UK and Spain and the role they play during times of difficulty or crisis. It has

highlighted the importance of social networks in the provision of support for older British people in Spain, which includes support from friends, family and neighbours as well as community and voluntary organisations including Age Concern España. It has shown that vulnerable, older British people in Spain are extremely heterogeneous; some maintain diverse social networks in multiple locations which they can draw upon for support, whilst others have very limited social networks and little support. It has therefore looked at the extent to which vulnerable, older British people in Spain are transnational and has shown that some are fully transnational by embracing Spanish and British networks and culture, whilst others are isolated from both countries. This has a significant impact on coping with challenges and therefore vulnerability.

The organising framework for understanding this was Grid and Group which identified four ideal types; the characteristics of each have been explored in this chapter. The Isolates have limited support, which for most is a close family member upon which there is a high degree of dependence. They are extremely vulnerable and are often unable to cope when a challenge arises and for some this has resulted in a need to return to the UK to access support. The Individualists are instrumental in their help-seeking, using their diverse social networks to draw upon the most appropriate source of support when required. As such, they are well placed to deal with a crisis when it occurs and are therefore less vulnerable. Enclaves also have wide social networks; however, these are restricted to other British people thereby limiting the diversity of support and access to formal support services. Hierarchy types have strong, diverse social networks, which they draw upon for support, whilst at the same time placing trust in experts. Their strong informal and formal ties allow them to cope effectively with any challenges that arise.

Whilst four ideal types are presented here, it needs to be recognised that there are some hybrid types, representing characteristics from two or more categories. Furthermore, a considerable amount of movement between groups can occur, especially as a person ages. Old age brings with it a decline in health, mobility, financial resources and friendships which in turn reduce social networks. As they age, some participants are displaying more Isolate characteristics, indicating the changes in and complexity of life during old age.

The thesis now moves on to look more specifically at the challenges facing participants, with the next chapter focusing on health and care challenges. Whilst the health and care issues facing respondents have been very briefly explored here, the next chapter looks in detail at health problems and the impact these problems have had on quality of life and vulnerability, including a discussion of access to health and social care services.

# **Chapter 6 - Health and Care Challenges Facing Vulnerable Older British People in Spain**

This chapter examines the health and care needs of older British people in Spain, focusing on the nature of health and care difficulties, as well as the availability of health and care support. Whilst the previous chapter primarily focused on the informal support networks of older British people in Spain including ties with family and friends, this chapter focuses on more formal and statutory sources of support, and rights to access that support. The survey of enquiries identified health and care as a significant area in which older British people in Spain require additional help and support (indicated by 42% of enquiries to Age Concern España being for health and care related issues). Many enquirers needed information on their healthcare entitlements, as well as on the availability of local support services. As identified in the previous chapter, most interview participants had encountered health challenges and a significant number were in need of care, especially the Isolates. These challenges are examined in more depth in this chapter.

This chapter begins by examining the health and care challenges facing interview participants and the impact these have on quality of life. This includes a discussion of the effects of declining mobility in old age and how this impacts on life in Spain. It then moves on to examine health and social care provision in Spain, including rights to and the availability of health and care services. It then looks at health and care as a reason for moving; including returning to the UK to access formal care and moving to Spain to access informal care. It finally examines the role of informal networks i.e. family and friends, in the provision of care and support during times of ill health or disability.

## 6.1 Health, Mobility and Quality of Life

The improvement of health is a commonly cited reason for retired British people to move to Spain (e.g. King *et al.*, 2000) and most interview participants reported better health after they moved to Spain than they had experienced in the UK. Most found that pre-existing conditions, such as arthritis and rheumatism, were improved due to the warmer climate:

I had like an arthritis of the muscles and if I had stayed in England with the weather I would have been in a wheelchair by now. So I needed to come down here because the atmospheric conditions are better for some people with this illness. (Amy, 52, Widowed)

[Terminally ill husband] wasn't well, he walked with a stick...we came here for his health. We came for a month for a holiday just to see and he was so much better...we always said he had five years more because the doctors said another winter in England, he would be dead. So he bought himself another five years if you like of life [by moving to Spain]. (Audrey, 66, Widowed)

However, despite the climate in Spain initially improving health, nearly all interview participants had also experienced a decline in their health since moving to Spain as a result of ageing. For some this was a minor complaint such as back problems or mild arthritis, whilst others had experienced a substantial decrease in their quality of life due to the effects of illnesses such as cancer, strokes, blindness or Parkinson's disease. Ill health brought increased vulnerability and frailty as well as mobility problems, which meant that carrying out everyday activities became difficult, including dressing or shopping:

When I dress myself it takes me about half an hour to be able to walk out here [into the lounge], I can't do much. (Wilma, 76, Widowed)

When you get to the [supermarket], you have got to walk around the place and get what you want, and then you are in the queue...and you have got to walk back with things to carry and have nowhere to sit. It is exhausting. (Elenor, 83, Widowed)

Falls were also common among participants leaving them with broken bones, sprains, cuts and bruises, which in turn reduced mobility and confidence further:

I was eight weeks in [house], walking around with a stick because I [fell]...I thought I would wash the patio at the back...I was just getting up off the step and wallop, I went straight on my face, I thought I had smashed my face, I could hear it all crunching, my teeth and my nose was bleeding, and I couldn't get up. (Elenor, 83, Widowed)

Falls pose a serious threat to the health and well-being of older people and research conducted by Weeks and Roberto (2003) shows that the physical and psychosocial consequences of falls can negatively affect quality of life. The impacts can include not only disability and loss of mobility but also lost independence and confidence.

A decline in health and limited mobility often led to an inability to go out, socialise and meet people, which in turn led to isolation and loneliness. As noted in the previous chapter, isolation was a common problem for some participants, particularly the Isolates. Isolation was often compounded by the design and location of a property, as those who lived in a remote area with few amenities were both socially and physically isolated from other people. For example, Lauren and Steven (a married couple) were two of the loneliest and most isolated respondents interviewed. This was largely due to the remote and hilly location where they lived, which had a lack of local amenities including public transport. Their health problems meant that they could not walk far or drive, so they could rarely leave their house. UK and Spanish based studies show that a rural location can cause isolation and exclusion (e.g. Dwyer and Hardill, 2008; Holbrook, 2004) and similar findings can be reported here.

The layout of a property was also found to limit mobility around the home. This includes steep stairs or narrow corridors, as Shirley explains:



You don't realise, as you get older that you may have a problem. I mean every time I use the [rooftop] solarium to put my washing out I count every step. There's 30 something stairs. It's not so much going down, it's going up. (Shirley, 87, Married)

The choice of property is therefore extremely important in the decision to move abroad and can be essential to well-being in old age. This requires good preparation before moving and a number of authors have noted that choosing the right property in the right location is essential to avoid isolation (Holbrook, 2004; Age Concern España, 2003b).

### **6.1.1 Mobility and Transport**

Physical isolation can also be caused by losing the ability to drive. Most participants found that a car was the best way to get around in Spain. Whilst car ownership was an "expensive luxury" for some, it was strongly associated with mobility and independence:

As I said I am a bit of a recluse but I like to feel that I am not bound. I like that freedom that a car gives you. Sometimes even if I don't need any shopping sometimes I just go shopping. Not that I need anything, it's to get out of the house. My car's there. (Robert, 72, Divorced)

This supports previous findings which show car ownership to be a symbol of independence and autonomy, and quality of life is often reduced when private transportation is lost (Davey, 2007; Gilhooly *et al.*, 2003). A lack of transport can also lead to mobility deprivation (Department of Transport, 2001). As they became older, some participants lost the ability to drive and in doing so lost a substantial amount of freedom, as Elsa explains;

"We were out during the days too, for tapas and drinks and things like that and would go to the beach and different places in Spain in the car. I miss the car ever so much. (Elsa, 78, Widowed)

A loss of transport can therefore result in not only physical isolation but also social isolation, as social activities become more restricted and confined to the local environment. For those with extreme mobility deprivation, all activities may become confined to the home (Droogleever Fortuijn *et al.*, 2006). Most participants still attempted to undertake social activities away from the home but in doing so were forced to rely on public transport or taxis. Others were able to draw upon family and friends who owned cars. However, relying on other people for transport was very limiting as noted by Wilma:

But the thing is, [friend] lives about 15 minutes away and when you get older you need someone to bring you, to take you and all this so it's not as easy. (Wilma, 76, Widowed)

Travelling to medical appointments also caused considerable problems for some participants without a car. Some complained about the difficulty and expense of getting to hospitals. Although it is possible to get a free ambulance to the hospital, this was found to be a complex process and therefore rarely used, even for those who spoke fluent Spanish as Audrey explained:

If you need an ambulance you have got to go through this ritual, of getting the Hoca de Transport, this form...and they have got to sign the back. Even the doctors don't realise that. They have to stamp the back to bring you back. It is a complicated system. (Audrey, 66, Widowed)

Some were able to draw on family, friends or Age Concern volunteers to provide transport to medical appointments;

[Age Concern volunteer] is fantastic, he gives up his like everybody else does for Age Concern and he takes me [to hospital] every time and without him I would be sunk no doubt about it. (Donald, 80, Single)

However, this was reliant upon people being available at the time of the appointment, so participants often had to rely on public transport or taxis; however, taxis were very expensive, and bus services infrequent and limited as Roger explained:

All of the specialists are in the Salud in the middle of town, which you have got to find your way to. And that's difficult if you are not mobile. That's difficult because there are no buses and it's quite a walk from the bus stops. Although, I suppose you could get a taxi but that's expensive. (Roger, 81, Married)

I have to go through the hospital for my tablets, I have got to pay somebody to take me there. I can't get the buses now, because a lot of them go different routes and its getting up and down them. So I have either got to get a taxi... there and back and it can make it expensive...there used to be people who gave me a lift but they have all got older and it's not possible. (Elenor, 83, Widowed)

Those living near large towns or cities with good public transport links had the fewest difficulties, whilst those living in a rural location or some distance from a bus route had the most problems. This again highlights the importance of choosing a property in the right location. Furthermore, those who were the most integrated and spoke Spanish found getting around the easiest, as they were able to speak to bus and taxi drivers about where they needed to go and negotiate on prices, as well as find information on transport services, such as free transport/ambulances to hospital appointments. Although pensioners in most areas of Spain are entitled to a free bus pass (as they would be in the UK), many did not use this facility because of language barriers restricting access to information and services. Alternatively, the noted difficulties of using the buses prevented people from using them. This was especially the case for less mobile participants who were unable to get on and off buses and some even expressed a fear of using them:

I am a bit frightened of the buses because it's a bit of a job getting on, but getting off, they take off. You know, I get frightened of them. I had a bus pass once, a free one but I never used it. (Robert, 72, Divorced)

Although transport problems and mobility deprivation are common for all older people (Department for Transport, 2001), older British people living in Spain appear to have more difficulties, particularly when they live in an isolated location and/or do not speak Spanish. This

can be a massive barrier to using public or hospital transport. In addition, health problems can also restrict the ability to fly, which in turn can result in isolation from friends and family in the UK, as discovered by Fred and Felicity:

Fred: I had a bit of minor...heart attack and they said, they told me that I can't fly for a period.

Felicity: So we can't go home...I don't think he would be able to fly again with this heart. They won't let him.

Mobility and transport difficulties can therefore have a significant impact on the lives of older British people in Spain. This includes the ability to access medical services and hospitals. The chapter will now move on to examine the healthcare entitlements of participants, including the different strategies employed to access healthcare in Spain.

## **6.2 Healthcare Entitlements for Older British People in Spain**

Access to healthcare services for older people in Spain can be restricted by age and economic status (Coldron and Ackers, 2007). Chapter Three outlined the different ways in which British people can access healthcare services in Spain, which includes; (1) through private health insurance schemes; (2) using public healthcare via reciprocal arrangements existing between EU member states (so costs of healthcare are recovered from the country of origin); or (3) some migrants are able to manipulate their residency status to secure the best healthcare coverage for themselves (Coldron and Ackers, 2007). Furthermore, migrants have also been found to use a combination of public and private healthcare schemes (Dwyer, 2001). Interview participants were found to employ each of these strategies as follows.

### 6.2.1 Using Private Health Insurance

Four interview participants (16%) had private health insurance policies. There were a variety of reasons why they chose private healthcare; some through individual choice and others through need. Robert was forced to take out private health insurance when he first moved to Spain, as he was under state pension age (SPA) but not working i.e. early retired. As a condition of residence in Spain (as set out in Directive 90/364 Article 1[1]) an immigrant must “be covered by sickness insurance” as Robert discovered:

When you come here, the Spanish government before you get your Residencia, insist you get [health] cover. (Robert, 72, Divorced)

When he moved to Spain he therefore took out a health insurance policy and then became a legal resident in Spain. When he reached SPA, he chose to continue with the policy because he found he is able to get hospital appointments quicker and he feels that private hospital staff are more likely to speak English or provide interpreters:

You can get in trouble with languages at the ordinary hospitals I think... Most of them speak enough [English], the private doctors, some don't in which case they will pick up the phone and ask for an interpreter to come which is good. (Robert, 72, Divorced)

Language was one of the key reasons why the other participants chose private healthcare. Language has been noted as a common barrier to accessing healthcare (Hardill *et al.*, 2005; Coldron and Ackers, 2007) and La Parra and Angel Mateo (2008) found that private healthcare is preferred by many British migrants due to language problems in the public sector. These findings are strongly supported here. However, La Parra and Angel Mateo estimated that 29% of British migrants in the Costa Blanca use private healthcare, which is more than the 16% of respondents in this study. However, the respondents in La Parra and Angel Mateo's study had an average age of 60 compared with an average of 78 in this study, which may indicate that younger British migrants may be more likely to use private healthcare. This may be due to the high cost of private healthcare in old age (Dwyer, 2001).

The remaining three participants accessed private healthcare through the ‘Helicopteros Sanitarios’ scheme<sup>10</sup>, commonly referred to as ‘Helicopter’; a private healthcare system operating in the Costa del Sol. This is a 24 hour mobile doctor service, which for a yearly fee provides minor and emergency treatment to people regardless of age, previous illnesses or residency status. As English is spoken by all medical staff and call handlers it is a popular service with non-Spanish speaking British people in the Costa del Sol. This was indicated by all three participants using the ‘Helicopter’ scheme speaking no Spanish (two were Isolates and one an Enclave). Whilst the ‘Helicopter’ service does not provide ongoing or inpatient care, all three participants relied quite heavily on the scheme. This includes Barbara who was not physically able to go to her doctor’s surgery, so instead used the Helicopter service for home visits:

I have asked for a home visit, but they don’t, so we joined her in the helicopter, if anything is an emergency, they visit. (Daughter of Barbara, 93, Widowed)

There were however, noted problems with private healthcare schemes. This includes some policies providing only limited coverage. For instance, Wilma took out a private health insurance policy when she moved to Spain, but later cancelled it when she found that it did not cover certain illnesses like pneumonia:

When we first came here we also had private insurance. But I shall tell you why we stopped having that. My husband was taken ill with pneumonia and we went to the clinic and after being there for about two, three hours, the young lady phoned the insurance company and they said your insurance doesn’t cover pneumonia so we had to pay the lot. (Wilma, 76, Widowed)

This indicates a lack of awareness on health insurance policies and as indicated in previous research, they can be of limited use for certain illnesses and when the need for long term care arises (Dwyer, 2001). Furthermore, an increase in insurance premiums with age was a problem for Robert who feels that he may have to cancel his policy as a result:

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<sup>10</sup> See <http://www.helicopterossanitarios.com/>

When I first came here [health insurance] was about 10, 20 pound a week, it's gone up, it's gone up, it's gone up. Even more recently since I passed 70 it keeps going up out of all proportion...I pay 130 a month...so you are talking well over a thousand pound [a year]. That out of a pension, one finds it difficult to keep up. (Robert, 72, Divorced)

Three out of the four participants using private healthcare were both over SPA and resident in Spain so were therefore also entitled to also use public healthcare in Spain. This supports Dwyer's research (2001) which found some migrants to use a combination of both public and private healthcare. Whilst, these respondents did use public healthcare services, they favoured their private healthcare for the reasons mentioned above and would only use public healthcare in instances when their private healthcare could not be used. For those using the 'Helicopter' scheme, public healthcare was used for non-emergency treatment or inpatient care. These respondents were therefore covered for every eventuality and illness, including for long term care. This indicates the ways in which migrants may maximise their rights using a combination of public and private healthcare to suit their needs (Dwyer, 2001). On the other hand, for Rachael, whilst she was over SPA, she was not a legal resident in Spain and therefore was not entitled to use public healthcare whilst in Spain. Her case is discussed in more detail in Section 6.2.3.

### ***6.2.2 Legitimate Use of Public Healthcare in Spain***

All except three of the interview participants were over SPA and resident in Spain, so were entitled to free healthcare in Spain by using the E121. Under this scheme, free healthcare is provided in Spain through reciprocal arrangements with the UK, which entitles recipients to the same level of care as Spanish nationals. Some used the E106 when they initially moved to Spain, however then applied for the E121 when this ran out, thereby maintaining legitimate use of public healthcare in Spain:

We were on the E106 [when we first moved]. If you move permanently then you get the E121 and we worked on [the E106] for a while before getting into the system. (Richard, 69, Married)

The two participants who were under SPA were working in Spain and paying national insurance contributions, so were therefore entitled to free state funded healthcare in Spain through their status as a worker. This entitled them to the same level of care as Spanish nationals:

I had worked here before, I had paid into the system before. When Spain became part of the European community...they said yes [I could use the Spanish healthcare]. So we became resident. (Robin, 62, Married)

Most found that the quality of Spanish public healthcare services were good, however for some, language did prove to be a barrier. State funded healthcare is discussed in more detail in Section 6.3.

### ***6.2.3 'Illegitimate' Use of Public Healthcare (in Spain and the UK)***

As noted by Coldron and Ackers (2007) some British people in Spain are able to manipulate their residency status to ensure access to healthcare. One participant (Rachael) could be placed in this category as she continued to receive healthcare in the UK whilst living in Spain. UK policy states that when someone lives outside of the UK for more than six months, they are no longer resident. Rachael is over state pension and lives in Spain for approximately nine months of the year (she spends the other three months staying with her daughter in the UK) and is therefore legally no longer a UK resident. However, she decided not to become a legal resident in Spain, because despite having lived there for six years, she still considers it a “trial” and may decide to return to the UK. She has not declared her change of residency in the UK, and by maintaining an address at her daughter’s house, she is able to continue to (illegitimately) use the British NHS. As such, she returns for any medical help:



I had a mammogram done [in Spain] last June and something did show up and three weeks later I was already going to England anyway. So I went off to England...and saw my doctor because I am still on the national health in England you see. (Rachael, 68, Widowed)

Whilst in Spain, she is not entitled to state funded healthcare because she has not legally registered, yet uses her EHIC (illegitimately) to receive healthcare. This entitles her to receive medical care in an emergency. Coldron and Ackers (2007) have suggested that some older British people in Spain purposefully defraud public healthcare systems by not registering, and this may be the case with Rachel. She may be intentionally manipulating her rights by maintaining her residency (and therefore healthcare) in the UK by using her daughter's address as her own in order to access the NHS. Whilst in Spain she then uses her private health insurance under the 'Helicopter' scheme or her EHIC illegitimately under the status of a 'temporary visitor':

I have got my E111 or whatever it is that you call it... I have got to change it to a [EHIC] card the next time I do go home [to the UK]. (Rachael, 68, Widowed)

### **6.3 Healthcare in Spain**

As has been found in previous research (Age Concern España, 2003a; King *et al.*, 2000), healthcare in Spain was considered to be very good by participants, with services being called "excellent", "brilliant" and "superb". Hospitals were found to be clean and long waiting lists were rare:

They had me in for different medical tests, and different things...things in the UK that would probably wait months and years for, you get here very quickly. (Robin, 62, Married)

As mentioned in the previous chapter Robin actually moved to Spain to have an operation (which he was entitled to do as he had worked in Spain), as he had been waiting on the British NHS for five years. Once in Spain, he was able to have two operations within 18 months due to shorter waiting lists. Other participants also found that if an operation could not be performed quickly at a Spanish publicly funded hospital, they were offered an appointment at a private hospital free of charge.

Some problems with health services in Spain were encountered; however, these were mainly due to language and cultural differences between services in Spain and the UK rather than the quality of services. Those who could not speak any Spanish experienced the greatest problems in hospitals and medical centres and even those who spoke Spanish encountered problems, due to complex medical terminology which is not spoken in everyday conversation. Participants found that only a small number of doctors and even fewer nurses spoke any English. Even when medical professionals could speak some English, they may not treat British patients without a translator being present:

The one I had before was [Doctor] and he was taught in England...but he will not speak English but everybody knows he could but he makes you speak Spanish. (Elsa, 78, Widowed)

Over half of all interview participants could speak very little or no Spanish, indicating that language barriers are a considerable problem. This has prompted a number of charities, including Age Concern España to establish a volunteer interpreter service at health centres, which are in huge demand from older British people. The majority of participants had used a translator at some time; however, access to translators was variable. Whilst many hospitals do not provide translators and patients are expected to provide their own if they do not speak Spanish, some participants found that other hospitals do provide translation services free of charge, indicating an inconsistency in information and service provision:

You can't have interpreters in Spain. Not free of charge (Richard, 69, Married)

That is another thing in the hospitals, you can get an interpreter any time you want [for free]. (Fred, 86, Married)

Some people were able to draw on their social networks for help with translating by asking friends, family or volunteers from British charities to accompany them to medical appointments. On the other hand, others used their own initiative such as buying medicines straight from the chemist rather than getting them from the doctors. Some also wrote down what they needed to say before seeing the doctor or used the ‘Tell the Dr’ book (available from Age Concern España), which translates key medical terminology. Others hired a translator or paid for private health insurance which included free translating services. However, this can also be problematic, not only because of the high cost but also because of translators misinterpreting information, as Andrew explains:

You pay for an interpreter, I had one once...I don’t know medical terms of things, and I sat there with this interpreter and I could understand what the doctor was saying and [the translator] interpreted it completely different so I thought this is a waste of money. (Andrew, 81, Married)

In addition to language barriers, many participants also encountered cultural differences in healthcare in Spain compared with the UK. As has been noted by Age Concern (2003a) one of the key differences is that care (e.g. washing, bathing and feeding) in hospitals is expected to be performed by family members rather than nurses, as Wilma explained:

You have got to have someone in [hospital] with you. The nurses will not help you out at all...When [husband] was ill, the two girls [granddaughters] and [daughter] took turns to stay each night with him. You have to stay the night otherwise you don’t get any help. When I wasn’t there, the dinner, nobody gives them anything. And then they take it away. They don’t feed you, they don’t wash you...If you don’t have anyone with you, you might as well die. (Wilma, 76, Widowed)

There were also differences in the design of the hospitals and wards, such as there being no curtain in front of the beds on wards, which one participant felt resulted in the loss of her privacy and dignity:

If you are in the first bed and you are a woman and the next bed is a young girl whose boyfriend comes in every day, and you can't get out of bed and you need a bed pan, there is no curtain. There is a curtain between the two beds, but it does not come in front of you. (Audrey, 66, Widowed)

There was also found to be a severe lack of aftercare, with problems being experienced following discharge from hospital, such as with organising transport, assistance in getting home and in information provision from the hospitals on aftercare such as wound dressing. A number of interviewees felt that they (or their partner/family member) were discharged too soon and were simply “bundled” off home:

My mother had a stroke. They kept her in hospital for 5 days and there was nothing more they could do for her so they just bundled her off home and when I say bundled I mean this. So this was a great trauma, and when she did come home she suffered terrible because well, you just don't get any help. (Wilma, 76, Widowed)

This indicates that medical care in the community is not available in Spain and King *et al*'s observation that there is a “virtual absence of community health services” (2000:183) is supported by participants here. Some found that doctors would not undertake home visits, unless they were private visits or covered by health insurance policies:

The aftercare [in the UK] was there. I can't fault that whatsoever. Out here [in Spain] it is very different, very different....when you come out of hospital, it could be 6, 7 o'clock at night, there is no aftercare and to try and get a doctor to visit you is virtually impossible, unless you go private. (Audrey, 66, Widowed)

As a result, Audrey had to pay for visits from private doctors. District nursing services were also very sparse, as were support services such as support groups for specific illnesses, for example a stroke victim support group was mentioned by one participant as something they would have wanted to be available.

## 6.4 Social Care in Spain

Community services in Spain are therefore sparse and support from Social Services was also different to that provided in the UK. As Social Services are provided by the 17 autonomous regions in Spain and through municipal local authorities in each region, there are considerable differences in services not only at a national level but within each local area (Miguel, 1998 cited in Tortosa and Granell, 2002). There was evidence of this here, with care provision varying considerably for participants:

When you come out of hospital, it doesn't matter how ill you are, you are on your own. At least in this area. I believe in some small areas, there is a nurse that calls. (Ida, 79, Divorced)

The majority of participants could find very little or no community care. There was however considerable variations in community support services as for example one couple received home visits from their doctor, whilst others stated that doctors do not undertake home visits. This may be indicative of regional variation in service provision or alternatively down to the discretion of individual doctors.

Differences in service provision were also seen with palliative care, which as King *et al.* (2000:191) note, is a somewhat “alien tradition”. Despite palliative services rapidly improving in recent years, there is still evidence of massive variations in provision (see *Fig. 6.1*). The extent to which participants are able to access such services, may in part be based upon social network characteristics and the ability to speak Spanish, as those participants such as Amy (a Hierarchy type – see *Fig. 6.1*), who can speak Spanish and has strong ties with local people, may

be more able to access local support services. They may be better placed to gather information on care (as this will often be in Spanish), and such people often have the cultural and social capital needed to access support.

***Fig. 6.1 – Two Experiences of Palliative Care***

- (1) Wilma's daughter approached Social Services in Mallorca for help with Wilma's terminally ill husband when they were unable to cope looking after him at home. They were offered no form of palliative care or support at home. The only care offered was a place at a day centre, which would have cost them approximately 800 euros a month and was not appropriate for a man who could not even stand unaided.
- (2) Amy lived with her husband and terminally ill mother-in-law in the Costa del Sol. They approached the local Hospice for help and they were offered day care. As the Hospice had no in-patient beds, a personal contact of Amy's who worked at the Hospice organised a place in a local nursing home with the only cost being her mother-in-law's state pension.

However, regardless of individual differences, the majority of participants found that there was insufficient statutory care provision to meet their needs. The key reason for limited social care in Spain is due to an expectation of the family to provide care (King *et al.*, 2000), meaning there is little need for formal care services and this was recognised by some participants:

In England you have got the District Nurses and people like that, but they don't do that here. I am not knocking the service here, the medical service is perfect ...But its just one of those things they don't do. They rely mainly on families here to look after people.  
(Andrew, 81, Married)

This represents different cultural practices between Spain and the UK and whilst the above quote shows that some British people are aware of these differences, others appear to move to Spain expecting the same level of care that they would receive in the UK. This indicates a lack of

preparation by some people on service provision in Spain. For example, Donald thought that if his health deteriorated he would be able to access a Spanish nursing home place in the same way that he would in the UK:

But I would think if I had any major problems, they would put me into one of these...healthcare places. [Donald, 80, Single]

However, in reality (despite the above example of Amy in *Fig. 6.1*), nursing homes in Spain are very sparse with research showing that places accommodate only 1.26 percent of the older population (Sancho Castiello, 2002 cited in Hardill *et al.*, 2005). Accessing nursing homes was a common problem faced by participants, and the only provision available tended to be private and very expensive. Nursing home places cost between 1500 and 5000 Euros per month (British Consulate, 2006) so this was not an option for most as the following interview with Barbara's daughter, Jane, indicates:

I: Is there any possibility of keeping [Barbara] in a nursing home in Spain?

Jane: It's over 2000 Euros a month.

I: Have you looked into state funded homes?

Jane: There aren't any. It's impossible. I have looked. I have looked. It was the first thing I tried. There are Spaniards queuing up for state homes so obviously they are going to give preference to a Spaniard anyway.

As a result, six participants felt that they were being forced to return to the UK to access residential care. This includes Barbara, who had to leave behind her daughter to return to a nursing home in the UK (discussed further in *Fig 6.3*).

Another option for care is sheltered accommodation, and this was mentioned by a number of participants. However, sheltered accommodation is not widely available in Spain, with the main provision being private and largely British-owned due to the high demand from British people in Spain. An example of this is 'Villa Martin Hills' in the Costa Blanca<sup>11</sup>; a complex for the over

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<sup>11</sup> See [www.villamartinhills.com](http://www.villamartinhills.com)

55's which has English speaking staff who provide 24-hour medical services and security, including a panic alarm in every apartment. There are distinct advantages of such accommodation for older British people, especially those who do not speak Spanish, and for those who are lonely or isolated. Elsa, an Isolate, is planning to buy an apartment in this accommodation complex and feels that the main advantage will be the ability to make new (British) friends and socialise again, something she has not been able to do since her husband's death:

There will be people there my own age who I can make friends with and I expect they will do outings... There will be coach trips and things like that. (Elsa, 78, Widowed)

However, sheltered accommodation of this nature is very expensive, with deposits alone being approximately 3000 Euros, and therefore only those who have sufficient financial resources are able to access such care. Whilst Elsa has some debts left by her husband, she also owns her own house which she will sell to raise funds. Therefore, in a similar manner to nursing homes in Spain, access to sheltered accommodation is also largely determined by financial resources.

#### ***6.4.1 Language and Cultural Barriers to Care***

For those who have the financial resources, private English-speaking care provision is an option; either in the form of sheltered accommodation, nursing homes or even care at home. However, most participants could not afford private care and therefore had to rely upon Spanish publicly funded care. In addition to the availability of care, interviewees suggested that the greatest barrier to accessing and receiving state funded care in Spain is language. Furthermore, cultural differences were also found to impede care provision. Language and cultural differences cause two key problems; they prevent people from obtaining care in the first place; and if care is obtained they cause communication barriers between the care worker and care receiver. For instance, Barbara receives help from a carer for three hours per week; however, she is unable to speak to her carer due to language barriers:



There's not really any communication at all [between Barbara and her carer]. [Carer] does what she is meant to do and that's it. Three times a week. (Daughter of Barbara, 93, Widowed)

Fig. 6.2 also highlights the difficulties faced by one participant living in a Spanish nursing home.

***Fig. 6.2 - Nursing Homes in Spain: A Lived Experience***

Harry is an 86 years old widower and lives in a Spanish nursing home. He can speak no Spanish and is not integrated, yet is living in a home where neither staff nor the other residents can speak English. He is unable to speak to anyone or ask for help. He is also facing cultural barriers such as with food in the home. As a result, he is extremely vulnerable, isolated and lonely:

I had my breakfast...I hate the food here, it's terrible I just do not like it. Today, I had, I don't know what it was, a sort of jumbled up egg. And they gave me some fruit, one or two bits of orange and a bit of something else. I usually get a cup of tea too at dinner time. I hate it here....

My daughter, thank God she brings in some cereal for me. I have that and a cup of tea. Then they decide what they are going to do [with me]...they leave me sitting there for a while. They usually take me out to the television room, and there is a door that leads out onto what they call the patio, they leave me by the door there... I go out when it's nice on the patio, by myself, I talk to myself...The problem is. I sit in a wheelchair all morning and my bottom gets very sore. I have told my daughter but it doesn't make any difference...

I: Can the nurses understand you if you ask them something in English?

Harry: No, most of them, no. Just the odd one. They can't speak English.

His only support is from his daughter and British charity volunteers who visit him approximately once a week.

Whilst Social Services are available in every area of Spain (although limited in comparison with the UK), interview evidence suggests that British people are not directly accessing these services, possibly due to language barriers. No interview participants had contacted Social Services for help and most were uninformed about Social Services, as they had no idea what they provided, where they were located or how to contact them. Whilst a few participants were receiving help from Social Services, this help had been organised by another person; either an Age Concern volunteer, or a friend/family member who could speak Spanish. This help includes tele-alarm systems with English speaking operators (via the Spanish Red Cross), carers and/or cleaners from Spanish Social Services.

Some respondents cited language as a significant barrier to receiving care in Spain and as a result, they intend to return to the UK when the need for care arises:

When I get really old, and I can't do things for myself, then I plan to go back to England. Most of the old people's homes here, apart from the private ones, which I couldn't afford, the majority of the people are Spanish. Whilst I like being on my own, I don't like not being able to communicate easily. (Robert, 72, Divorced)

This would suggest a huge need for additional care services for elderly British people in Spain, such as British-owned and run nursing homes. As was noted in Chapter Three, some EU nationals (Dutch and Norwegians) can access nursing homes in Spain provided by their governments. But to date this is not the policy of the British Government for their nationals. Whilst the provision of such nursing homes would be costly, it would reduce the need to return to the UK to access care, which is also costly both financially and emotionally (Hardill *et al.*, 2005).

## **6.5 Moving for Care**

Care was a prominent feature cited in the reasons for moving either to Spain or back to the UK for a number of respondents. Previous research on moving for care has largely focused on

returning to the country of origin to seek care; either informal care and support from family, or formal state funded care (e.g. Ackers and Dwyer, 2002; Malcolm, 1996; Wilson, 2000). Whilst returning to the UK for care was a motivation for some respondents in this study as mentioned in the previous chapter, others actually moved to Spain in the first place to either receive or provide care. This section therefore focuses on motivations for moving involving decisions about care. It looks at returning to the UK to receive care, moving to Spain to receive care and moving to Spain to provide care.

### ***6.5.1 Returning to the UK to Receive Care***

As mentioned above and in the previous chapter, seven participants were planning a return move to the UK; either imminently or in the near future. One of the main reasons for returning was to access care (cited by five respondents as the primary reason for returning). This was due to a lack of care provision in Spain, the high cost of private care and/or language and cultural barriers to care in Spain. Most respondents had no family in Spain and were therefore returning to be close to their children or siblings in the UK. In addition, all seven participants wanted to return to the UK in order to access care from UK Social Services.

Ackers and Dwyer (2002) found that some older people return to their country of origin out of choice following a change in circumstances, and this was the case for some respondents including Robert as mentioned above. Such a move is often pre-planned as for example Robert had already arranged a place in a UK nursing home if his need for care increases. On the other hand, Age Concern (2007) found that some older migrants may be forced to return to the UK when they can no longer live independently and there are no support systems (most frequently care) in the host country. Such a move may arise as a result of an unexpected crisis or unanticipated change in circumstances, such as a radical decline in health or bereavement. This was the case for Barbara who was returning out of the necessity for immediate care and would rather remain in Spain if given the choice. Those who were returning usually spoke no Spanish and had no links with the Spanish community (the Isolates and Enclaves), suggesting that those who are not integrated are the most likely to return to the UK when things go wrong.

As outlined in Section 3.4, returning to the UK to access care is a complex process. All seven interview participants who wanted to return, felt that they were not given enough information from UK Social Services. For example, a married couple who had experienced severe health problems and were in need of residential care decided to return to the UK. However, when they looked into this more they found a lack of information available to them, such as on the type of accommodation they would be provided with:

Who was meeting us at the airport we don't know? I was trying to find out where we were going from the airport and they couldn't tell us...we could be standing at the airport or put in some kind of boarding house, so we thought no, we would forget that. (Fred, 86, Married)

This caused a huge amount of emotional distress due to a fear that they may become homeless or destitute upon return to the UK, and as a result they approached Age Concern España for assistance with finding a place in a Spanish nursing home. They were lucky to live in an area where nursing home provision was available and as such, they were able to remain in Spain permanently. Some were able to seek help with their repatriation from Age Concern or Heathrow Travel Care. Such organisations are able to help obtain access to nursing homes in the UK; however as *Fig. 6.3* shows, the process of doing so is not always straightforward.

***Fig. 6.3 – The Challenges of Returning to a Nursing Home in the UK***

Barbara is returning to a nursing home in the UK with assistance from Age Concern and Heathrow Travel Care. At the time of interview, Travel Care were negotiating with Local Authorities in the UK for a place in a nursing home. However, an assessment of her health needs was first required meaning that upon return to the UK she must first access a hospital for a health assessment before being transferred to a Social Services department. Only if her care needs are deemed critical, would she then be able to access nursing home care. An additional barrier is the Habitual Residency Test (HRT), which she must pass before being able to access any support. This could take up to three months and she may only be able to access temporary accommodation until the test is passed. With regards to accessing healthcare upon her arrival, she must be deemed to be 'ordinarily resident' and this requires proof of address (this can be up to six months utility bills). Therefore, upon arrival in the UK she will only be entitled to emergency healthcare and is not guaranteed a place in a nursing home.

*(Based on case summary material from Heathrow Travel Care, 2007/2008).*

### ***6.5.2 Moving to Spain to Receive Care***

To date, research on moving to receive care has largely focused on those who return to the country of origin and as discussed in the previous section, this did occur quite frequently among respondents. However, moving for care can also involve a move away from the country of origin and this study also identified four respondents who moved to Spain in order to receive care from family. As briefly discussed in Section 5.1, five of the Isolate respondents moved to Spain to be close to their daughter who already lived there. For four of these Isolates (Barbara, Harry, Lauren and Steven), this was as a result of a decline in health and the need for care and support which was to be provided by their daughter who had moved to Spain many years before to work. This section focuses on the experiences of these four Isolates. The other Isolate (Wilma) who moved to be close to her daughter initially moved to provide care and is discussed in the next section.

These four Isolates moved to Spain in old age, with the age of migration ranging from 79 to 85 years old. The average age of migration was 82 years old. They had all experienced a significant decline in health prior to moving and were in need of care. This is in contrast to the majority of retired migrants (King *et al.*, 2000) and indeed the majority of other interviewees in this study who move to Spain in the 'Third Age' when they are happy and healthy. Instead, these four respondents moved during the 'Fourth Age' (Laslett, 1991), which is the final stage of life when frailty, disability and social exclusion are common (Bond and Corner, 2004). They were therefore very frail and vulnerable at the time of moving. The experiences of vulnerable older people who move abroad to receive care have been largely neglected from research to date. This is recognised by Ackers (2004:383) who notes that "where care is a factor in the migration decisions of elderly persons, it is typically assumed to involve returning home in order to access family care"; however, she found moving abroad in old age to receive care from the migrant family does also occur.

The Isolates who moved for care encountered a greater number of difficulties than most other respondents, with the greatest problem being social isolation and dependence on their daughter. Ackers (2004) recognises that social dislocation is a problem facing those who move for family care and argues that such a move is not a "practical or desirable solution for either party" (2004:386). This is echoed by Wilson (2000), who argues that moves by frail older people involving long distances to be close to family can cause problems such as isolation and a resulting dependence on family. The social dislocation of moving a frail elderly person to Spain especially when they do not speak Spanish proved to be difficult for respondents (also see section 5.1 outlining the experiences of the Isolates):

[My parents] want to have someone to talk to of their own age and in the same language and somewhere with shops nearby and places that they can walk to. (Daughter of Lauren and Steven, 93/87, Married)

Moving in old age meant that these Isolates did not have the ability to develop their own social networks outside of their immediate family. This was as a result of poor health and mobility

severely restricting any activities they wanted to undertake. These Isolates were restricted to the home and unable to go out, socialise or make new friends:

All she can do is go downstairs [to the apartment restaurant]. Not in the street but just down to the restaurant. (Daughter of Barbara, 93, Widowed)

They were therefore completely dependent on their daughter which left them in an extremely vulnerable position as they have no other sources of support. This was recognised by Barbara's daughter:

If anything happens to me, [Barbara] is basically stuffed. (Daughter of Barbara, 93, Widowed)

These Isolates moved only for the support and/or care that would be provided by their daughter, so Spain as a country of migration was not their choice as it was for the remainder of respondents. As only children there was no other family support available, so most daughters felt they had no choice but to care for their elderly parent(s) in Spain:

I couldn't leave [Barbara] alone in London... If I had brothers and sisters, it could have been easier, but I don't. (Daughter of Barbara, 93, Widowed)

[Harry's wife] couldn't cope any longer [looking after Harry]... I didn't have any option [but to move Harry and his wife to Spain]. (Daughter of Harry, 86, Widowed)

Caring for an elderly parent proved to be a difficult and time consuming job, especially for those who also had to work, leading to further isolation and loneliness for the Isolates:

With working all the time I don't, I can't do 24/7 care. (Daughter of Barbara, 93, Widowed)

[Daughter] has got her own problems. She is working. She has got a mortgage to pay. I don't see much of her. She was meant to come over on Tuesday but she didn't. (Harry, 86, Widowed)

Whilst similar problems may occur for families living in the UK, a limited amount of state funded care in Spain and language/cultural barriers to care, means that accessing any additional formal support is difficult. This led to further dependence on their daughter and greater isolation:

They can't go into a home in Spain because of the cost and also because they do not want to go into a Spanish home where they could not speak to anyone due to language barriers. (Daughter of Lauren and Steven, 93/87, Married)

As a result of these difficulties, three of the four Isolates who moved to Spain to receive family care, are now returning to the UK. For Barbara, this is for a nursing home and for Lauren and Steven, it is for sheltered accommodation. The other Isolate, Harry, whilst not returning to the UK, feels that he would be much happier living in the UK in a nursing home rather than remaining in Spain (see Fig. 6.2). An eventual return home therefore appears quite likely for those who move to Spain for care. Moving to Spain for care remains a largely under-researched area, so further studies are recommended.

### ***6.5.3 Moving to Spain to Provide Care***

One respondent moved to Spain to provide rather than to receive care. Although Wilma moved to Spain to live with her daughter, this was before she reached old age (at the age of 46) and at the time of the move she was in good health and not in need of care. She moved to be near to her daughter who moved to Spain for work and was having a baby. Wilma moved to support her daughter and to help bring up her granddaughter:



The reason I came to live here was because this is where my daughter and her husband lived so I came to live with them...my daughter was married to a Spaniard and she was pregnant with my granddaughter. (Wilma, 76, Widowed)

A parent moving to support their children whilst they work has been recognised as a reason for migration (Ackers and Dwyer, 2002). This usually means helping them to run the home and look after grandchildren and this was the case for Wilma. Wilma moved to live with her daughter and now continues to live in the family home with her daughter and grandchildren. However, over time as her health has declined, this relationship with her family has changed and she has become more dependent and is now reliant upon them for everyday activities.

The situation of Wilma is quite different to that of the previous four Isolates, the main difference being that when she moved she was not elderly and dependent on her daughter. She was young and fit enough to socialise and as a result she is less isolated than the four respondents discussed in the previous section. She also made the choice to move to Spain, which arose from visiting it when she was younger:

When I first came to Mallorca, I fell in love with the island and my daughter was 3 or 4 years old and we went all over the island and I fell in love with here, a long before she fell in love with her husband. (Wilma, 76, Widowed)

She did not move as an Isolate, but instead became an Isolate in Spain following a decline in her health and need for care. Whilst caring for her husband, bereavement and her own decline in health has led to vulnerability and a decline in social networks and support outside of the family, her experience is more positive than the other four Isolates discussed above.

## **6.6 Informal Support with Health and Care Challenges**

This chapter has so far highlighted the experiences of participants with regards to health and social care challenges and the nature of support received. The previous two sections highlighted

the importance of family in the provision of care in old age and looked specifically at care as a reason for moving. This section therefore looks more generally at the informal support and care provided by family and friends, as well as charities and voluntary organisations, in response to a decline in health.

### ***6.6.1 Informal Support from Family and Friends***

Most interview participants were able to obtain support with their health and care problems through their informal social networks, including from family, friends and neighbours. Previous research (e.g. Lynch, 2007; Phillipson *et al.*, 2001; Allan, 1989) has noted how family and friends tend to play different roles, with family providing practical/personal care and support during illness and disability, whilst friends are less engaged and tend to provide emotional support or advice. However, for vulnerable, older British people living in Spain, primary care from family is usually limited by distance. With the exception of some Isolates, the close family of interviewees lived in the UK so could not be relied upon for practical and ongoing support (except from a spouse/partner for married participants). Instead, the nature of support from family was usually provided over the phone or through visits:

I had one of my daughters here and she was helping and another daughter came out as well. But they can't be here all the time obviously. She said, dad, you have really got to get some help. Get mum in a home or get someone to come round, she said. (Andrew, 81, Married)

This supports the work of Baldassar (2007) who found that migrants can exchange emotional care over a distance using the telephone and ICTs, however personal care is much more difficult to provide. Therefore, whilst it was possible to provide emotionally involved care work, it was not personal or primary care as this requires a physical presence. Instead care from family was less engaged and often limited to the offering of advice or emotional support. As a result, those living away from their family were often quite independent:

I couldn't ask [daughter] to come out and help with all the personal things I had to do for [husband]. I couldn't ask a 30 year old to come and do that. (Audrey, 66, Widowed)

This is indicative of Wenger's (1997) *wider community focused support network*, which occurs where family do not live close by and support can be generated from friends in place of family. This is supported here, as for most participants, friends and neighbours were essential in the provision of support. The previous chapter highlighted the importance of friends in the lives of most participants (with the exception of the Isolates), and this was especially true during times of ill health or disability. For the majority of participants, friends provided a range of support, including emotional support during illness and also following bereavement or bad news:

Yes, friends who I have had over a number of years, who I have had 30 years, still phone me up...So yes, I have a lot of support if I want it, if I need it. If I am really down I can phone them up. (Audrey, 66, Widowed)

Support from friends also included practical help, such as with shopping, transportation to hospital, the translation of medical information and translating at medical appointment:

My two what I call my best friends, I have known them virtually from when I first came here...they would come to the hospital, one of them would and speak to the doctor for me. (Audrey, 66, Widowed)

This other [nurse]...she gave me a diet sheet the other day, I had to ask somebody down the road [to translate]. (Victoria, 67, Married)

The lady next door comes in and helps. She is Spanish. When she was here yesterday she told [wife] she has just moved and said you can ring me up any time in the morning...She said if anything happens again, if it is one, two, three o'clock, telephone me. (Felicity, 80, Married)

In addition, friends were often a key source of information on health and care services, as well as on support services such as Age Concern:

I: Why did you contact Age Concern?

Gabrielle: Because I heard it from a friend.

Friends were also often the first point of call during a medical emergency:

[When my husband was dying] my friends came and stayed with me and I stayed in the A and E and 5 o'clock, the next morning he gave up the fight. (Audrey, 66, Widowed)

[Husband] couldn't understand what was going on and he realised [I was having a stroke] and then [friends] came round. They called an ambulance. (Richard, 69, Married)

Wenger (1997) found that people with *wider community focused support networks*, tend to have an abundance of help in emergencies; however, long term care and support was more difficult to obtain. There were a small number of participants who did receive personal care from friends, including Audrey whose neighbour looked after her terminally ill husband (see section 5.4.1). However, long term care was more difficult to obtain from friends than family and support from friends was mainly limited to the practical activities discussed above, including shopping and transport.

### **6.6.2 Support from Age Concern**

Age Concern España were an important part of most interviewee's support networks. Volunteers often played a key role in supporting participants during times of ill health or disability. Whilst they did not offer any personal care, they often provided a strong source of emotional support:

[Age Concern volunteer] is such a good lady. When my husband was dying she said don't worry, any time of the day, I am here for you. I mean, she had never even met me

before, let alone talked to me before. I am here, ring me up even if it is one o'clock in the morning, I will be here. And that to me is wonderful. (Amy, 51, Widowed)

It's such a relief even just to talk to someone [from Age Concern España] and the amount of care and concern that has been shown towards us, it's absolutely amazing. (Mary, 81, Married)

In addition, they were able to provide practical advice and information including the names of private carers, links to care homes, links to Social Services and other organisations and even information on funerals:

Age Concern have been brilliant here. They are so needed, they really are. Its amazing what they can do to help. When I needed something, like finding out how to donate our bodies. It was through them that I got the form to find out where to write to, you have to write to the University of Alicante. They are there to help but they are the only ones. (Audrey, 66, Widowed)

They also organised the repatriation of some participants to the UK, as the earlier example of Barbara shows. Some participants had also received support from other British charities in Spain, including Help (see Section 3.7), which offers similar services to Age Concern. The role of voluntary organisations in the support networks of vulnerable, older British people in Spain can therefore be crucial during times of illness or disability.

## **6.7 Summary**

This chapter has examined the health and care problems facing vulnerable, older British people living in Spain. It has shown how a decline in health can radically reduce quality of life, especially by limiting mobility and increasing isolation. Whilst health problems are not unique to those living in Spain, the nature of formal and informal support available can be different to

that in the UK. This includes support from formal health and social care services which can differ radically between Spain and the UK. Whilst medical care in Spain is considered to be excellent, social and community care is limited due to the expectation of the family to provide care in Spain. In addition, language and cultural barriers are preventing access to support services. Informal support can also be limited as most older British people living in Spain do not have family nearby to provide care. Whilst this has encouraged British people to develop their own networks of support, such as through new friendships and British charities, they can only go a certain way in the provision of care. There is therefore a massive demand for more care to be made available to older British people in Spain, such as through British run nursing homes. Whilst it is not the responsibility of the British government to provide care for British nationals living abroad, it may prevent the need for some to return to access state-funded care which has huge financial and emotional costs.

The next chapter examines the financial challenges facing older British people in Spain and the ways in which such challenges are managed. As discussed above, financial resources can impact upon the ability to access health and care services. This will be examined further in the following chapter.

# Chapter 7 – Living in Spain: The Financial Costs and Benefits

In addition to good social support and health, vulnerability in old age can be determined by financial resources. Financial security is linked with successful ageing (Warnes *et al.*, 1999) and quality of life (Gabriel and Bowling, 2004). Most older people are on a fixed income, usually a pension, meaning that financial security upon retirement is crucial. Financial difficulties tend to increase with age, and often arise during the 'Fourth Age'. Whilst 'Third Agers' tends to be those in good health who are financially secure, the 'Fourth Age' tends to bring a decline in health and also financial resources (Bond and Corner, 2004). This may arise as a result of changing circumstances with ageing including bereavement or the need for care. Financial difficulties can lead to increased vulnerability (Grundy, 2006), as well as social and financial exclusion due to a loss of purchasing power, i.e. the ability to purchase goods and services including care (Scharf *et al.*, 2004).

This chapter examines the financial difficulties faced by vulnerable, older British people living in Spain. It specifically looks at how a lack of material resources can contribute to vulnerability, exclusion and ultimately a poor quality of life. It highlights the financial challenges faced by participants and their capacity to cope with these challenges. It also identifies the relationships that exist between financial disadvantage, physical (health) resources and social support. The chapter begins by looking at the financial circumstances of vulnerable, older British people in Spain. It then considers both the financial advantages and disadvantages of a move to Spain, as well as the main causes of financial difficulties. Many UK welfare benefits are not exportable to Spain, and the impact of this on older people is demonstrated. It then looks at the nature of financial support available to and accessed by participants, including support from informal and formal sources. It finally addresses the difficulties faced when returning to the UK for financial help. The financial challenges faced by participants are examined throughout the chapter using

indicative case studies and quotes, which are used to highlight the multifaceted nature of financial issues and how these impact upon the lived experiences of participants.

## **7.1 Financial Resources in Spain for Vulnerable, Older British People**

### ***7.1.1 The Changing Financial Circumstances of Older British People in Spain***

Previous research has suggested that the majority of older British people who retire to Southern Europe are in a financially privileged position (e.g. Ackers and Dwyer, 2002; Warnes, 1992), because in addition to a state pension, they may have an occupational/private pension and additional sources of income such as investments or savings. Most also own their own property, which they may sell to finance the move abroad (Williams *et al.*, 1997). However, there also appears to be a significant number of older British people living in Spain with a low income (below 60 percent of the median income for the UK) and who are entirely reliant on state benefits. This includes at least seven of the households interviewed who were totally dependent on their British state pension.

This may indicate a shift in the social class of older migrants, with greater numbers of people from lower social class groups moving abroad. King *et al.* (2000) reported that older British people who move to Southern Europe may now be less affluent than they were ten or twenty years ago, be from lower social class groups and have lower education levels. The study estimates a third of such individuals to be from social class groups three, four and five (semi-skilled and unskilled). This would suggest that as migration is becoming more affordable and accessible, a wider range of people are moving which includes lower socio-economic groups who have less economic capital. This is likely to result in a growing number of households of older British people living abroad in financial need and has clear implications for British and Spanish policy.

Older age groups are those most likely to have a low income, as evidence suggests that those over 75 years of age are often reliant upon state benefits and many do not have an occupational



pension (Burholt and Windle, 2006). This can be supported here as all of the seven households reliant on the British state pension comprised of respondents 75 years or older. Such people were found to lack economic capital, which gives access to most goods and services and is recognised by Bourdieu as the most important resource (Bourdieu, 1986). Without economic capital, participants lacked purchasing power and material resources. For some, this included their own home or even the basic requirements of living, such as food. This also radically limited the ability to purchase care, which impacted upon health challenges (discussed in Section 7.2.1).

### ***7.1.2 Gaining Financial Advantages through a Move Abroad?***

As mentioned in Section 3.3.1, economic advantages feature very highly in the reasons why older British people move to Spain. This includes the benefits gained from cheaper living costs, as well as fiscal and tax policies (Williams *et al.*, 1997). Lower living costs include lower house prices, lower heating costs and the low cost of eating out in comparison to the UK (O'Reilly, 2000a). This is supported by all 25 interview participants who generally found living costs in Spain to be lower than in the UK and cited it as a distinct reason for moving or at least an advantage of doing so:

We had had enough [of England]. We couldn't afford to stay there anymore. (Amy, 51, Widowed)

[Friends said] we have got a little [house] in Spain and she said you can go there and you could live for a year on what you are spending on just a fortnights holiday. (Mary, 81, Married)

As a result of cheaper living costs in Spain, participants felt that they could achieve a better quality of life, which for some included being able to eat out more often:

We manage our finances better here than we did at home [in the UK] ... We can go to the Chinese for a meal. Five euros, its nothing. But at home [in the UK], I don't think we'd be able to go out for a cup of coffee and a bun. You see? There is more to offer us here, with going out. We can go to the Chinese, or anywhere for that matter, for the, what do you call it, the menu del dia? And that is a morning or afternoon out. Whereas in England, we wouldn't be able to afford to do that. (Mary, 81, Married)

We go out here we can go to a restaurant and we can have a lovely meal, 3 course meal, wine and everything else and it is 8 euros, which is about 6 quid. I mean, you can't buy a hamburger in England for that. So another thing, it's the style of life. It's a nice style. (Andrew, 81, Married)

There were therefore some distinct financial advantages of living in Spain, including the ability to go out and socialise more, which can in turn helps to generate social networks. However, whilst some things remain inexpensive, such as the cost of eating and drinking out, those interview participants who had been living in Spain for at least five years, all commented that they had noticed a considerable increase in living costs over the past few years:

Four years ago, five years ago things were a lot cheaper in Spain than what they are now. (Roger, 81, Married)

[Living costs] were good but I mean they are getting so high. Everything has gone up, the rent has gone up, electric has gone up terrific, water has gone up terrific. (Sheila, 74, Widowed)

I survive on a Widow's Pension. That was difficult enough but coming over here it went further, a lot further when it was pesetas, but now since we have had the euro, things are going up they really are...I have to count the pennies more...I daren't get into any debt because I am on a fixed amount from England. (Rachael, 68, Widowed)

Rising living costs include increases in the cost of basic requirements such as housing, utility bills and food. This has had a considerable impact on those on a fixed income who are struggling to pay their bills. Age Concern (2007) suggest that as a result of increases in such living costs, many older British people in Spain are being left with insufficient funds, and this can dramatically impact upon their general well-being and quality of life. This is supported here.

In addition to rises in living costs, further difficulties can arise as a result of exchange rate fluctuations. This particularly affects those who are living in Spain yet receiving their income from the UK, including their state pension and other benefits as discussed in Section 3.3.1. Age Concern have seen a rise in financial problems among older British people in Spain. The survey of enquiries conducted for this study in 2006/7 showed around 9% of enquiries to Age Concern España being for a financial issue; however, Age Concern now estimates that this figure has increased significantly and they have seen a growing number of older British nationals at risk of destitution in Spain (Age Concern, 2008). Such exchange rate fluctuations are likely to have a significant impact on those reliant on the British state pension, which includes at least seven interviewed households. Furthermore, those reliant on savings or investments also saw a drop in the interest they received from them.

A substantial drop in the value of the pound was also seen in the late 1980's/early 1990's and this had a considerable impact on British people who were living in Spain at the time. This includes Robert, who has lived in Spain for 22 years, and spoke of the financial problems he encountered due to a change in the exchange rate:

That's another thing, when you retire so early you come over with what you think is enough money to see you through, which is fine...then suddenly, instead of 240 pesetas to the pound, it suddenly goes down to 169 and the interest rate drops from 10 to say 3 so before you know where you are you have spent half of your capital. (Robert, 72, Divorced)

As a result of a decline in income, individuals such as Robert are left with reduced purchasing power and this can increase vulnerability. Financial difficulties were being (or had recently

been) encountered by 13 out of the 20 households interviewed, which had negatively impacted upon their quality of life. The causes of these difficulties are now discussed.

## **7.2 Financial Difficulties**

Financial difficulties arose for a number of reasons. Some had experienced ongoing financial difficulties as a result of a low income. This was especially the case for those reliant on a fixed income, such as the state pension. Financial difficulties were however more likely to arise due to a change in circumstances during old age including the onset of a crisis. Bereavement was a frequent trigger for financial difficulties among interview respondents, as for example Amy experienced a severe financial crisis following the death of her husband. Before his death, her husband's pension was their only source of income and when he died she was left with no income or savings. She also had to find the money to pay for his funeral:

When my husband was really, really ill...I was panicking about money and I didn't know what to do and I didn't know how to do all the paperwork...I can't afford the funeral I don't know what to do. (Amy, 51, Widowed)

Elsa also encountered a financial crisis following the death of her husband, who (unbeknown to her) had taken out a number of loans, which she became liable for following his death:

When I lost my husband, dear oh dear where can I start. My husband he liked this high-tech stuff, dvd's, videos, televisions and all that...he spent so much money on that kind of equipment... I didn't know anything about the loan...I keep getting letters from them...I have been paying quite a lot for these mobile phones. (Elsa, 78, Widowed)

Unexpected bills as well as bureaucracy issues were another cause of financial difficulty. For instance, Rachael lives in an apartment block where she must pay service fees. Since a new

management team were established, she has found her fees have increased dramatically, even to the point where she is receiving bills which she cannot pay:

The first bill came in. 500 euros. That's my part to get the gardens done, to paint the outside...[I said] I'm so sorry but my pension does not allow me to pay you 500 euros for anything. I don't have 500 euros. So I put my cards on the table and told them no way would I be able to be part of it. I have now had another [bill] for another 500 euros making it a thousand...I have got a number [of a lawyer] but it is going to cost me...another 125 euros for a one hour consultation with a good Spanish lawyer. (Rachael, 68, Widowed)

This recent crisis is coupled with increasing local taxes (urbanisation fees), meaning that Rachael has little or no disposable income from her fixed income:

Urbanisation fees which at the moment stand at, they have just gone up, 280 euros, 200 pounds a quarter. (Rachael, 68, Widowed)

Financial difficulties can also arise as a result of insufficient financial preparation before moving to Spain. Whilst most participants had a sufficient income to survive when they first moved to Spain, this income may not last or additional income may be required as a result of ageing. For instance, Wilma moved to Spain 30 years ago to work for the family business; however, she had no formal contract, was not paying any tax and therefore was not entitled to a Spanish pension as her granddaughter explains:

[Wilma] had no contract because it was in the family hostel, which is a problem because then you don't get the proper...pension and benefits. (Granddaughter of Wilma, 76, Widowed)

As a result, Wilma's only income at the age of 76 is a small British state pension. She is living with her family in Spain and could not afford to move out. A series of crises recently led to extreme financial hardship for Wilma, beginning with the family business in Spain failing,

leaving their household income very low. Around the same time her husband became ill and in need of 24-hour care, which they could not afford. Their financial situation declined further when her husband died as they needed to find the money to pay for the funeral. This highlights how inadequate resources can either cause or exacerbate other problems. This includes health problems and the resulting need for care.

### ***7.2.1 Health and Financial Resources***

Financial crises were related to a sudden decline in health for some participants (in themselves or their spouse). Whilst health problems may not directly cause a financial crisis, financial resources can be required to purchase care services. As a result, paying for care services can exhaust financial reserves. Furthermore, for those with insufficient financial resources the amount and type of care received can be limited and insufficient. As discussed in Chapter Six, for older people living in Spain where state funded care is sparse, the inability to purchase care services can cause a significant decline in quality of life and well-being. This highlights the importance of economic capital and its ability to purchase particular services (Bourdieu, 1986), which for older people can be care services. This can be seen in the example of Barbara and her daughter who encountered a series of related health, care and financial crises following her move to Spain. This began with her daughter separating from her husband which meant that their financial situation dictated the need for her daughter to return to work full-time. This meant that she could not care for Barbara as they had planned:

My mum came out [to Spain], I was married...It was at my husband's suggestion, because I was going to retire and could basically look after her. But a year and a half ago he left me and I have to work. He left me without money, so I have to work morning and afternoon...When I brought her out here I thought I could do all the looking after because I would still be married but nobody knows what is going to happen. (Daughter of Barbara, 93, Widowed)

The marriage breakdown was followed by a severe decline in Barbara's health and her need for 24 hour care, which was only available privately. At this point, Barbara and her daughter had very little disposable income so could only afford three hours of care per week. The story of Barbara, as detailed in Chapter 5 (*Fig. 5.3*), shows that her inadequate financial resources and need for care resulted in a return move to the UK. This was primarily to access the British social security and care systems. This case highlights the uncertainty of life and the impact of unexpected events. Furthermore, it demonstrates the links between insufficient financial resources and vulnerability, as well as a poor quality of life in old age (Gabriel and Bowling, 2004; Grundy, 2006).

On the other hand, participants with relatively high levels of economic capital were seen to cope more effectively with their health problems, resulting in overall better well-being. This includes having private healthcare or having the ability to purchase private care services. For example, when Andrew needed a hip replacement, he was able to utilise his economic capital to purchase private healthcare to avoid a six month waiting list for a hip operation:

[Hip operation] needed doing again. They say it's bad ... I saw the doctor and he said come back and see me in about six months time. Six months I said, I can't wait six months in pain. The kids came out in August, it was my birthday, we were all celebrating, with the grandchildren, and he said why don't you pay for it and have it done private... So I went to [hospital] and had it done in there last September. (Andrew, 81, Married)

Economic capital was also utilised by some participants to employ a cleaner which meant that they did not have to undertake the physical work involved in housework. Some found housework to be very strenuous, sometimes to the extent that it was detrimental to their health:

We have got a friend of ours now, she comes and cleans the house, does the housework, once a fortnight or once a week. We pay her of course. It takes a bit of the heavy work off. (Andrew, 81, Married)

I have got a young girl who helps me for two hours a week, to clean. But for a long time I did clean myself, and the woman I had, she went back to Portugal and thought I would do it myself. But now I have this young lady. I keep myself busy. I do some of the garden and I have somebody to cut the lawn of course. (Gabrielle, 89, Widowed)

Economic capital can therefore be used to cope with health and care challenges. Research shows a strong link to exist between income and health, even to the extent that those with more financial resources are likely to have better health (Burholt and Windle, 2006). This is largely due to a higher level of purchasing power and therefore an ability to buy the goods and services that will maintain health, including private healthcare and additional care and support.

### **7.3 Welfare Benefits in Spain**

As mentioned above, most participants had a fixed income and were reliant on the British state pension. Whilst the state pension is exportable to Spain, many other social security benefits are not. In addition, Spain has a less generous welfare system than the UK and provides few welfare benefits. These barriers to welfare were found to affect participants in two ways; (1) an inability to export benefits to Spain led to a decrease in income for some participants when they initially moved to Spain; and (2) when a financial crisis arose in Spain, additional financial support in the form of welfare benefits were not available. Therefore, whilst financial difficulties are encountered by many older people due to their fixed income, the financial support available to older British people living in Spain is much lower. They are therefore more vulnerable if a crisis, such as a decline in health, occurs.

For example, Sheila moved to Spain 34 years ago and undertook casual work from which her income was low. She was able to survive on this, yet had little disposable income. When she fell and hurt her leg a few years ago, she was forced to give up work and with costs of living in Spain rising she is now unable to manage on her small British state pension. If she had lived in the UK when she stopped working, she would have been entitled to benefits such as pension



credit and disability benefits; however, in Spain there were no such benefits available to her. As a result, she feels that she may be forced to return to the UK out of fear that she will become destitute in Spain:

I have always had financial problems out here but I have never owed anybody anything but I have always had to struggle...When you can't work you go on sick pay [in the UK], don't you? Nobody in England is poor really, they have all got money haven't they? Out here you have nothing. When you are sick you have nothing... I know I just can't afford [to live]. I am going to the hole in the wall all the time and there is going to be a time when there is nothing left. (Sheila, 74, Widowed)

Financial problems can arise due to insufficient preparation. Various authors have found that a lack of research by older migrants can leave them unaware that their benefits will be stopped as soon as they become resident in Spain (BBC, 2006; Age Concern 2007). Some participants did appear to be uncertain about what benefits they were and were not entitled to and some had tried to claim benefits from Spain that were not exportable:

We used to have some, what's the name, care allowance. I got that or we got that because I was looking after her. But when you come out here you can't get that. I have tried like mad to get it back, no chance, no chance. (Roger, 81, Married)

This does indicate a lack of preparation on the part of the participants, as there was a general assumption that when they encountered a financial crisis, the UK welfare state would help. This indicates an ongoing reliance on the UK and a lack of recognition that Spain has a different legal structure where benefits are not widely available. However, it may also indicate a lack of information, or an inability to understand the information that is available. Whilst there is some good information available on the exportability of benefits, such as leaflet SA29 produced by the Department for Work and Pensions (DWP), this can be hard to find and may involve complex web searches. As such, participants often appeared to be unaware of the existence of information on benefits:

You go through all the motions of phoning up or trying to get the information, which is not easy sometimes even though they speak English but it's a job to get through to the right place, with all these call centres. I think they should make a leaflet for...what you are or what you are not entitled [to] and what you have got to do to be entitled. (Robert, 72, Divorced)

A further example is of Robin who moved to Spain four years ago and for the first two years continued to receive his Incapacity Benefit and Disability Living Allowance (when in fact his DLA should have been stopped immediately). Both were then stopped without any notice, however following an appeal he has since had his Incapacity Benefit reinstated (as this is exportable under EU Law). This may highlight insufficient information provision by the UK authorities, which in turn causes confusion among claimants of benefits. Robin is now facing extreme financial hardship in Spain even to the extent where he cannot afford his rent and food costs and feels that this is in part due to a lack of information and support:

This is where I am getting really disgruntled with the UK. If they decide to pay me they will have to transfer all my contributions sooner or later. It is a very grey area. Nobody knows what's happening. You ring up [the DWP in] Newcastle or Blackpool and they don't know what to tell you. (Robin, 62, Married)

It would appear that Robin did all the preparation necessary before moving, which includes finding out about his health and benefit entitlements as he explains:

We had sorted out all the medical side, what we were entitled to, if we could become residents, what would we get health wise. General stuff. And I checked with the benefit people and they said, yes it would be alright and all of a sudden this DLA [stopped]...they didn't even tell me they had stopped it...They didn't say about this 26 weeks then. This is what I am saying, it was very vague. (Robin, 62, Married)

Some respondents, including Robin, felt very strongly that as UK nationals and tax payers they should be able to continue to receive their benefits in Spain. This again indicates an ongoing

reliance on the UK for financial help. Furthermore, it appears that some older British people move to Spain with the implicit assumption that their financial needs will be met; when in reality this is not always the case. This was also demonstrated by Felicity:

They won't give me anything from England because I am not living there and that annoys me. I think I worked until I was 62, paid all my insurances. I did tell them on the phone...We haven't got a lot of money but we manage. I have tried to get, well you couldn't do it now, but I have tried to get, what's it called...the disability allowance, but they said no. Definitely they said no. I had all the letters, but we are alright as we are, we are waiting to see what they say when they come, see if they can get it sorted. (Felicity, 80, Married)

There was also some confusion around Winter Fuel Payments (WFP), as some participants were able to claim it whilst others were not. As detailed in Chapter Three, the criteria for claiming a WFP are based on the age at the time of moving, as well as the year in which the individual moved. Those participants who moved to Spain prior 1998 or who had reached pension age in Spain were therefore unable to claim the benefit:

I mean, they [older British people] come out here now and they get winter fuel allowance. Because they had it in England they get it out here. That's ridiculous, isn't it? Us that have been out here all this time get nothing. And they don't need winter fuel allowance, so that is a ridiculous waste of money. (Sheila, 74, Widowed)

As this quote suggests, some feel that the WFP should not be paid in Spain due to less need for heating during the winter months in comparison with the UK. Some were disgruntled about those who did receive it as in fact most did not actually spend it on heating:

Now that we are 80 they have given us heating allowance as well, which still helps although we don't use it all on our heating. It's very good actually, top whack. So that's another 4 or 500 pound a year that we get. (Roger, 81, Married)

Winter fuel payments therefore appear to act as an old age benefit rather than serve the purpose for which it was intended i.e. to pay for fuel. This therefore raises questions around the exportability of other benefits.

Since the data for this study was collected, Disability Living Allowance, Attendance Allowance and Carers Allowance have been made exportable within the EU. This will certainly improve the financial situation of those who move to Spain with care needs as they will be able to use this money to purchase care services in Spain. However, these benefits currently cannot be claimed after moving to Spain. This thesis has shown that some older British people are returning to the UK to access care and financial support (discussed further in Section 7.7) and therefore an alternative solution to address the care needs of older, British national in Spain and prevent them returning could be in the form of a Direct Payment. Suggestions have been made to provide Direct Payments to British nationals living abroad to purchase their own care (MacErlean, 2007), providing they have paid sufficient National Insurance contributions. Whilst the UK government is not responsible for providing care to older British people living abroad, doing so could prevent the financial and emotional cost of a return move to the UK (both for the UK government and returnees). However, at the current time, this appears unlikely to happen.

## **7.4 Financial Support in Spain**

Due to restricted rights to access welfare benefits in Spain, vulnerable, older British people must seek alternative ways to cope with their financial difficulties. This can include generating support through social networks. This section will consider the extent to which financial support can be gained through informal networks of family and friends, as well as from more formal (non-government) sources of support, including charities. However, first the links between good social support and financial well-being in old age are considered.

#### ***7.4.1 Financial Resources and Social Capital***

Research indicates that good financial resources not only improve quality of life and well-being in old age, but can also increase the capacity for developing and maintaining social networks by extending opportunities for acquaintances (Kosteniuk and Dickinson, 2003), as well as increasing participation in community activities (Davis Smith, 1992 cited in Burholt and Windle, 2006). Bourdieu (1986) argues that those rich in economic capital are more likely to accumulate social capital and this can be supported here. Those who had some disposable income were able to take part in local events and join social clubs which resulted in more friends and local ties. Whilst most participants had little disposable income, a very small number of Hierarchy participants were financially quite well off, so were able to use their economic capital to, for example, join golf clubs and go on social outings, thereby contributing to their Hierarchy status:

We have made quite a lot of friends at the golf club you see, we both play golf ... we have got Dutch friends and Belgian friends and one or two Spanish friends but it all revolves around the golf course. (Andrew, 81, Married)

Then they started these other trips for a week, Granada, or Valencia or Madrid and places like that, so I started booking those and friends of ours at the golf club said they would like to come...We would go to hotels and all come down for a meal, then they would have dancing in the evening then they would take the coach somewhere else. (Andrew, 81, Married)

Economic capital in this situation can therefore be used to ensure access to groups and networks, which in turn generates social capital. On the other hand, those with a low income are more likely to have a poor social life and fewer friends, as they are financially constrained from taking part in social events that cost money. This also includes the cost of travelling to social events, even if the events are free. Whilst most interview participants were able to take part in low-cost social activities, some found that their social lives were restricted by their financial resources largely due to being unable to eat out and join in with social events that cost money:

We don't do a lot really. We walk down the beach, we walk about. Socially...we haven't got a lot of money to go anywhere. (Robin, 62, Married)

One of the most significant financial constraints was the cost of returning to the UK to visit friends and family. As discussed in Chapter Four, this can result in limited transnational participation (Duval, 2006). This was the case some interview participants who, as a result of financial difficulties, were unable to maintain strong ties with friends and family in the UK:

I: Do you ever go back to the UK?

Robin: No. We have got nobody. [Wife] has got a sister in Derby, but we can't afford to go.

My sister, I ring quite often, but she's 82, she's not very well...I'd like to see her but it costs me a lot of money. She is in the UK. (Elsa, 78, Widowed)

Therefore, financial resources can either improve or restrict both local and international social networks. Social networks can provide emotional and practical support with financial problems (Burholt and Windle, 2006). This can clearly be seen with the interview participants, as having good social support helped some to overcome and cope more effectively with financial challenges. Those participants who had little social support (most notably the Isolates) tended to experience particularly negative outcomes from their financial problems. This includes a number of Isolates feeling "forced" to return to the UK due to financial constraints in Spain. The impact of informal social networks on financial challenges is now considered.

#### ***7.4.2 Financial Support from Family and Friends***

For some interview participants, financial support came from their informal support networks of family and friends. Whilst family and friends provided emotional support when financial problems arose (as they did with health problems), family were more likely to provide actual financial help (in the form of money or other material resources).

The most common type of financial help from family was with accommodation, particularly for those interview participants who were living with or in a property owned by a family member. The five Isolates living near or with their daughter were all reliant upon them financially, thereby indicating another level of dependence. For example, Barbara is living in an apartment owned by her daughter as she could not afford to buy her own, and Lauren and Steven are living in an annex on their daughter's house because they also could not afford to buy anywhere themselves either in Spain or the UK. Others were able to stay with their children for free when they returned to the UK and family sometimes assisted with the cost of flights. This was one way in which some participants were able to maintain their transnational relationships despite financial difficulties:

I went home several times last year. But having said that this is where my family come in...I don't have to worry about the plane tickets. They are very good to me...[Son in law] said have you got the ticket he didn't even ask how much it was he just put notes in an envelope and said thanks for coming and that will see to your plane fare. When I go they would be terribly upset if I offered anything for staying there. (Rachael, 68, Widowed)

However, despite financial help sometimes being offered by family members, most participants did not like to burden their family with their financial problems, turning to them only as a last resort (see for example data from Rachael in Section 5.2.1).

On the other hand, friends were, at times, a valuable source of support with financial difficulties, particularly the Hierarchy and Enclave types who had many good friends. This did include practical help with financial difficulties. For example, when Amy's husband died leaving her with severe financial problems to the extent that she could no longer afford her basic living costs including her rent, her Spanish friend offered her accommodation at a very low cost and gave her a job working in her restaurant:

[Friend] is only charging me 300 Euros a month and that includes my food, and electric and water. I couldn't stay in the apartment I had, even though the landlord said he would

reduce the price. When I was working for another company, I was working to pay the landlords and I couldn't do it anymore, it was stupid. (Amy, 51, Widowed)

Without this financial support from her friends, Amy feels that she may have had to return to the UK to access welfare benefits. As a Hierarchy type with a significant network of support, Amy was also able to draw on her family and friends for emotional and practical support.

Other sources of indirect financial support came in the form of free or very cheap help with household tasks, including cleaning from friends. For example, whilst Fred and Felicity could not afford to pay a cleaner, their good links with the local community meant that a friend who is a cleaner helps them out:

Fred: The lady next door comes in and helps. She is Spanish.

I: Do you pay her?

Felicity: We did then. It's minimum. She only takes all I have in coins. I have been throwing things out, you know, and I have numerous things I have bought and never worn so I gave them all to her. She says no.

Therefore, the amount of emotional and practical support available with financial challenges can vary according to social networks. For the Isolates, informal support is very limited and largely restricted to one or two close family members, whilst the Enclaves and Hierarchy types have large informal networks to draw upon, which for some led to multiple offers of emotional and practical support. Individualists on the other hand, often used their acquaintances to generate informal and formal financial help, often from within the Spanish community.



## 7.5 Formal Financial Support

### *7.5.1 Support from Age Concern España and Local Organisations*

One key source of support for participants with financial problems came from British charities in Spain. Whilst all participants were clients of Age Concern, those with financial difficulties had all found the organisation to be an excellent source of support. This support ranged from actual financial help (through the provision of money or other material resources), to emotional and practical support to deal with the outcomes of a financial crisis. Some participants also used Age Concern for information or to access other forms of financial help, often from benevolent funds (see Section 7.5.2). Eight interview participants were somewhat dependent upon Age Concern España to deal with their financial problems and some even felt that they would have been unable to cope with their financial crisis without Age Concern; either financially or emotionally.

This includes Elsa, an Isolate, whose financial crisis began when her husband died and as mentioned in Section 7.2, she was forced to organise their financial affairs which included repaying a number of large debts that she became liable for upon her husband's death. Elsa had no family nearby, or any close friends, so she turned to Age Concern for help. A volunteer helped her to understand her financial accounts, went to the bank with her, contacted the loan companies and helped her to set up monthly repayments. Elsa became largely dependent upon the volunteer without whom she feels that she would not have been able to cope as indicated by this conversation between Elsa and the Age Concern volunteer:

Elsa: She has been so helpful this girl [volunteer] she really has. I don't know what I would have done without her.

Volunteer: You would have probably managed.

Elsa: I don't think so.

Volunteer: It was a bit of a difficult situation, but everything got sorted in the end. That was what was important.

Elsa: Thanks to you.

Age Concern were also able to provide emotional support as well as advice for participants with their financial and bureaucracy problems. This includes the provision of information and help navigating bureaucracy:

When my husband was really, really ill...I was panicking about money and I didn't know what to do and I didn't know how to do all the paperwork... I phoned Age Concern and said...I can't afford the funeral I don't know what to do. [Volunteer] said leave it with us, we will sort it out. Don't worry... Obviously, when you have got someone like [volunteer] to explain rules and regulations; I don't know the regulations in England let alone in Spain. Having [volunteer] there to say do this or do that or don't do this or don't do that. She is wonderful. (Amy, 51, Widowed)

Age Concern were therefore a key source of emotional and financial support for some participants, especially those without close family and friends to help them, as the above case of Elsa highlights. The Isolates were the most likely to become dependent upon Age Concern for support, as would be expected due to their high level of dependency on others for support.

On the other hand, some interview participants were able to utilise local support services for help with their financial problems. This was mainly the Individualists whose ties with the Spanish community allowed them access to Spanish organisations (see for example discussion on Robin in Section 5.3.1). Therefore, again we can see that social networks are key to accessing support for financial problems, as those with extended networks of British and Spanish people, can tap into various types of support rather than rely on one or two people. Robin's social networks, language skills and integration allowed him to access support from local Spanish services as well as Age Concern and benevolent funds. This is especially important for those living in Spain, due to minimal state-funded financial support.

### ***7.5.2 Support from Benevolent Funds***

Benevolent funds from HM Forces charities, occupational charities as well as voluntary organisations, were a source of financial support for respondents. Age Concern has its own benevolent fund from which some participants were able to seek financial assistance. If an individual is in financial need and either themselves or their spouse has served in HM Forces or have worked in a specific occupation, they are entitled to apply for a grant from that charitable fund. This includes six participants who had received grants from either Age Concern España, the Royal Air Force (RAF), the Royal Marines, the Royal Navy, the Royal Army Service Corps or the Royal Corps of Transport. Grants came in the form of either a one-off monetary amount or ongoing payments for a fixed period of time.

Robert receives an on-going payment grant from the RAF Benevolent fund of approximately £20 per week which he uses to boost his current low income. He has come to rely on this grant and feels without it, his purchasing power would be lost:

Age Concern recently and the RAF have managed to help me with some extra income, which makes a lot of difference. When I was running through the capital, that was a constant worry thinking is it going to last?...The RAF give me so much each quarter...This is the first year I have got it and that's why I said things are a bit easier when I am getting this. (Robert, 72, Divorced)

Alternatively, one-off payments from benevolent funds were used to buy equipment, home improvements or to pay for accommodation. For example, Age Concern funds bought Elenor some new dentures, and installed a ramp to her house when her husband was in a wheelchair, neither of which Elenor could afford herself, but both of which dramatically improved her and her husband's quality of life:

I had that door put in and the steps [ramp] so that I could push him down. That all cost money, [but] it meant I could push him straight out onto the patio. Before I would have to push him in there, get him in the kitchen, ask him to stand up whilst I got the chair in,

then opened the door and sit him back down. [It meant we could go out and] have something to eat and that was nice. (Elenor)

*Fig. 7.1* shows where the grants awarded to the six participants came from and what they were used for. This varied from paying rent, to paying for British television and new furniture. However, in every case, the grant increased that person's quality of life by making their standard of living more comfortable and relieving financial burden.

***Fig. 7.1 – Grants Awarded to Participants***

<b>Participant</b>	<b>Grant Awarded From</b>	<b>Grant Used For</b>
Sheila	RAF Benevolent Fund (BF)	New sofa. Living costs.
Wilma	RAF BF	Funeral Costs. British television.
Elenor	Age Concern BF	New dentures, patio door and ramp.
Robin	Royal Marines BF Royal Navy BF Royal British Legion	Rent. Living costs.
Robert	RAF BF	New garden patio. Living costs.
Amy	Royal Army Service Corps BF Royal Corps of Transport BF Age Concern BF	Funeral costs. Rent.

Formal financial assistance from benevolent funds had, for these six participants, been organised through Age Concern España, who acted as an intermediary. Therefore, instead of participants contacting the benevolent societies themselves, Age Concern had made the initial contact, filled out the forms and organised the payment transfer:

[Age Concern volunteer] got [funeral payment] for me. She filled in all the forms and sent them to me and I had to sign it and send it back to her and then she dealt with it.  
(Amy, 51, Widowed)

This is because most benevolent funds do not take self-referrals for financial help and instead use third party organisations such as Age Concern. This means that financial help from such sources can be limited depending on whether an individual has contacts with voluntary organisations. As all of the interview participants were clients of Age Concern España, they all had the ability to access benevolent funds; however, there will be older people living in Spain in need of financial support who are entitled to grants, yet do not have the networks to access them. However, what is clear from the interview data, is that such forms of financial support can be vital to financial security and therefore a better quality of life in old age. The impact of such support was considerable for some participants, including Robin who was at risk of destitution in Spain.

Robin was facing severe financial difficulties and was at risk of losing his home due to rent arrears. Through Age Concern España, he was able to secure grants from the Royal Navy and Royal Marines benevolent funds to pay for four months rent:

I'm catching up with the rent arrears so that's alright. I'm only a couple of months behind now. But thanks to the Marines and the royal benevolent fund. That covered four months rent. What happened was that money went to Age Concern ...I got awarded a couple of grand from the Royal Marines and one from the Royal Navy Benevolent Fund, nearly £2000...just to help me out. Through Age Concern, [volunteer] she sorted me out. I had to do all the form filling...So we have also applied to the British Legion. (Robin, 62, Married)

Robin also received food parcels from Age Concern España which provided him with the basics to live on:

[Volunteer] gives us food parcels every couple of months...pasta. Not luxurious food items, just stable diet, healthy diet stuff, tinned tuna, tinned salmon and stuff like that which is very nice. (Robin, 62, Married)

The Age Concern Benevolent Fund have also been used to cover the cost of funerals, as found by both Amy and Wilma, as following the death of their husbands, they did not have enough money to pay for their funeral:

When you have got a bill for 1000, 1500 euros for a funeral we just don't have it...so [Age Concern] have really helped, because [Age Concern] paid for the funeral. (Wilma, 76, Widowed)

There are therefore huge benefits to accessing help from benevolent funds and charities, yet there are likely to be many people unaware of such sources of support. Any help that is available should therefore be more widely publicised, as those who are not in contact with organisations such as Age Concern, would be unlikely to access this form of financial help. The survey of enquiries to Age Concern España shows that over half (53%) of older British people in Spain (or their spouse) have served in HM Forces and may therefore be eligible for financial support from HM Forces benevolent funds. However, this number is likely to dramatically decline in future generations meaning that financial support from HM Forces based charitable funds will not be available to them. This may become a significant problem in coming years and some thought needs to be given as to where the current young retired generation living abroad will receive financial help from.

This may include occupational-based benevolent funds. Whilst a number of interview participants were aware of occupational benevolent funds, none were receiving financial support from them. Two had applied for grants; Wilma who had applied for a grant from the Butchers Benevolent Institution (through Age Concern España); and Robert who wanted to access a place in a British nursing home funded by the National Advertising Benevolent Society. However, at the time of interview, neither had actually received any help. Grants from benevolent funds to some extent replace the UK welfare system as they allowed some interview participants to remain in Spain rather than be forced to return to the UK. This includes Robin and Amy, who felt that the grants they received enabled them to remain living in Spain.

## 7.6 Returning to the UK for Financial Support

As discussed in the previous chapter, a number of interview participants were returning to the UK to access additional support. Whilst research shows the most commonly cited reason for older British migrants to return to the UK is to access health and social care services (Dwyer, 2000; Warnes *et al.*, 1999), some also return to access financial support in the form of welfare benefits. This includes four of the households interviewed who at the time of interview were about to return or were thinking of returning to the UK in order to access the welfare system for benefits which were not available in Spain. This includes pension credit and housing benefits.

However, returning to the UK for financial support is a complex process. The previous chapter highlighted the problems associated with returning to the UK for care, and similar problems arise when returning to access welfare benefits. The biggest difficulty facing returning British migrants is that in order to receive any welfare benefits, they must pass the Habitual Residency Test (HRT) (outlined in Section 3.4). This means that income-based benefits, such as Pension Credit, cannot be applied for until a person is declared as habitually resident and this usually takes around three months. Even after passing the HRT, applications for benefits can take an additional two to three weeks (Age Concern, 2007). Therefore, immediate financial support is not available.

For those seeking Housing Support, the HRT must be passed before any accommodation is provided. Furthermore, to be placed on a Housing Association list, a person must already be habitually resident. This has caused substantial problems for some interview participants, including Lauren and Steven, whose daughter was organising their return to sheltered accommodation in the UK. Their daughter found that although they wanted to return to a permanent base in the UK, "...they cannot get onto a Housing Association list until they are resident in the UK" (daughter of Lauren and Steven). As a very old, frail couple (93 and 87 years), they have poor health and limited mobility, and so needed to "...settle down somewhere straight away" (daughter of Lauren and Steven) rather than be housed in temporary accommodation. They therefore felt that they had no choice but to opt for private sheltered

accommodation. However, their limited finances gave them little choice about where they could live, causing further problems and isolation from the few friends and family they did have.

Whilst Lauren and Steven may have been eligible for housing support, the HRT meant that they were not able to access this immediately upon their arrival. They were a vulnerable, elderly couple so were unable to move around between different forms of temporary accommodation and as such had to pay for private housing leaving them with no disposable income. As frail, vulnerable British nationals resuming their residence, they should be able to pass this test immediately and/or arrange their care before leaving Spain.

### ***7.6.1 Information and Advice***

As identified in the previous chapter, a further difficulty facing older British nationals when they return to the UK is accessing information. For those returning for financial support, there appears to be a lack of information particularly on accessing housing upon return. Most participants did not know how to access financial support upon their return, or what their rights were in the UK. They therefore felt there was a need for clearer and more widely available information on repatriation:

There is a lot [of information on repatriation and benefits] on the internet, but you can't get to the bottom of it...There is no clear information and it is difficult to make any sense of what there is. (Daughter of Lauren and Steven, 93/87, Married)

Insufficient information from Social Services and Local Authorities proved to be a significant problem for those wanting to return for residential care or housing. Some people were afraid of returning as they did not know what the procedures were once they arrived in the UK and this includes information on the HRT, which some interview participants were either entirely unaware of, or were unsure of how the test worked. It was felt that there should be clearer and more widely available guidelines, especially for those with no money, poor health and without family or friends to support them:



If you are unwell and not able to choose the time [to return], what happens then? There should be guidelines. I'm not frightened out of my wits about it because I know I have got a son and grandchildren in England...On the other hand there are other people who haven't got that and if I didn't have that, it would be frightening. (Robert, 72, Divorced)

Information is therefore a key area for improvement, particularly information and guidance on returning to the UK, including on the HRT. Information on the exportability of benefits and healthcare, as well the availability of care services in Spain, are also areas recommended for improvement.

## **7.7 Summary**

This chapter has examined the financial advantages and challenges for vulnerable, older British people living in Spain. Whilst lower living costs are a distinct advantage of living in Spain, this can be negated by rising living costs and exchange rate fluctuations. Most interview respondents had encountered financial difficulties and for most, this had dramatically reduced their quality of life. Financial support is not widely available for older British people living in Spain, with a limited number of welfare benefits being obtainable from Spain or exportable from the UK. Financial difficulties often arose as a result of declining health and the need to pay for care. Whilst the relatively new exportability rules for DLA, AA and CA may begin to improve the financial situation of those moving with care needs, this will not help those who develop care needs whilst living in Spain.

Some respondents turned to the voluntary sector for financial support, including benevolent funds from British charities, such as Age Concern España and HM Forces charities. However, such support is often limited and not available to all, so some respondents were being forced to return to the UK to access financial help. As also discussed in the previous chapter, (re)gaining residency in the UK can be a lengthy and often traumatic process. Whilst the British government is beginning to recognise the problem and has introduced a DWP funded support and liaison

team to assist British nationals needing advice on financial issues, they do not provide actual financial help.

The following chapter concludes this thesis and draws together the key themes from this and the previous two data analysis chapters. It also discusses the practical implications of this study, including the policy recommendations.

## Chapter 8 - Conclusion

This thesis has examined the experiences of older British people in Spain, focusing in particular on those who are vulnerable and in need of additional support. Previous research on the British community in Spain has tended to focus on the reasons for moving and the experiences of those in the 'Third Age' of life (except see Ackers and Dwyer, 2002; Hardill *et al.*, 2005). However, this thesis tells the 'other story' by examining the lived experiences of ageing in Spain, instead focusing on those in the 'Fourth Age' of dependence and decline. It has examined the challenges and crises faced as a result of ageing, which tend to be centred on a decline in health, the need for care, bereavement and insufficient financial resources. These are common difficulties faced by many older people; however, this thesis looks at these challenges within the context of living in Spain where language, culture and legal barriers restrict access to support. In doing so, it has looked at the networks and services that support these individuals and the extent to which they provide care and support during times of need. It has also addressed the location of networks and support structures and therefore the extent to which vulnerable, older British people in Spain are transnational by generating support from more than one country.

This concluding chapter brings together the key findings of the study, as detailed in the previous three chapters, by outlining the broad theoretical and practical issues inherent in the research. It begins by showing how the research aims were met and how the study provides an original contribution to knowledge. It then looks in more detail at the three main resources that contribute to old age vulnerability; health/care resources, financial resources and social resources and each are discussed in turn. It then moves on to address the social and support networks of vulnerable, older British people in Spain. This focuses on the type of support, from where this support is generated and therefore the extent to which respondents are transnational. It also briefly discusses the experiences of returning to the UK to access support. The chapter concludes the thesis with the practical outcomes of the study by outlining a series of policy and practice recommendations, as well as some recommendations for further research.

## 8.1 Meeting the Research Aims and Contributing to Knowledge

This thesis has contributed to existing knowledge through the achievement of the following three research aims:

### Aim 1

*To examine the lived experiences of vulnerable, older British people in Spain focusing on the difficulties and crises they face as a result of changing life circumstances with ageing.*

The needs of vulnerable, older British people in Spain were initially identified through the survey of enquiries to Age Concern España as being centred on social support, health/care and financial issues. These were explored further through the in-depth interviews and became the focus of the three data analysis chapters. Vulnerability largely arose due to the limited availability of and access to health/care services, as well as financial support in Spain. However, the ability to cope with vulnerability or a crisis also depended on the availability of social networks for support. Those with small or restricted networks were the most vulnerable, whilst those with large networks which could be utilised for support were the least vulnerable and best placed to cope with any challenges or crises that occurred.

### Aim 2

*To examine the kinds of support networks that vulnerable, older British migrants construct and access in the UK and Spain (e.g. family network, friendship network, voluntary sector) and the role that they play during times of crisis.*

The social networks of respondents were essential in the provision of support during times of need. This included informal support from family and friends, and more formal support, such as from charities. To examine the social networks of vulnerable older British people in Spain, the Grid and Group theoretical framework was utilised to present four distinct types of social organisation: Isolate, Enclave, Individualist and Hierarchy. The framework identifies the size

and type of social network and where the network is located, as well as wider social, cultural and institutional factors that impact upon vulnerability, such as integration. This is the first time the framework has been used to look at vulnerability and support in old age and its utilisation in this thesis makes an original contribution to knowledge (discussed further in section 8.3).

### Aim 3

*To examine the impact of UK, EU and Spanish policy on the rights of vulnerable, older British people living in Spain to access health care, social care and social security.*

Policy was found to have a considerable impact on the daily lives of respondents in three key areas; healthcare, welfare and returning to the UK. British nationals of state pension age registered as living in Spain are entitled to the same level of health and social care as Spanish nationals; however, cultural and language barriers can restrict access to care. Welfare support in Spain is also different to the UK with only some UK benefits being exportable to Spain, leaving some vulnerable, older people with a limited income. As a result of such difficulties, some migrants decide to return to the UK to access both formal and informal support. However, residency restrictions, including the Habitual Residency Test (HRT), led to difficulties in returning and therefore increased vulnerability and distress. A series of policy recommendations have been made as an outcome of this research and these are detailed in Section 8.5.1.

## **8.2 Ageing in Spain: The Multiple Dimensions of Vulnerability and Quality of Life**

This thesis has focused on older vulnerable members of the British community in Spain. It has shown how vulnerability can arise as a result of and be exacerbated by insufficient social support, physical/health resources and financial resources. Physical, financial and social resources can therefore enable or constrain successful ageing and the achievement of a good

quality of life in old age (Gabriel and Bowling, 2004; Grundy, 2006). Older people tend to be more vulnerable than younger groups as they face more challenges (including a decline in health, loss of income or the loss of a spouse) and also have reduced resources available to overcome these challenges (Schroder-Butterfill and Marianti, 2006). Older British people living in Spain may be especially vulnerable, as support from the UK and Spain may be limited by distance, cultural/language differences and rights to access health, care and welfare support.

### **8.2.1 Health and Care Resources**

Old age is often a time of physical decline and ill health, resulting in reduced mobility and increased dependency on both formal and informal sources of support (Grundy, 2006). There are significant numbers of older British people in Spain encountering health and care difficulties, as indicated by 42% of enquires to Age Concern España being for health and care related issues. Furthermore, most interview respondents had encountered health problems that had negatively impacted upon their quality of life. However, gaining formal support from statutory and other local health and care services in Spain was often difficult due to cultural differences in service provision. As noted by other authors (King *et al.*, 2000; Betty and Cahill, 1999), there is a largely absent aftercare service in Spain, as well as limited community care facilities, palliative care services and care homes. Furthermore, language barriers often impeded access to those services that did exist.

In addition to formal support services, informal care during old age is often provided by family members (Phillipson *et al.*, 2001; Allan, 1989); however, for older British people living in Spain, care from family living in the UK may be limited by distance. Whilst some interview respondents had a daughter living nearby in Spain who did provide care, for the majority, family members lived in the UK. Whilst some were able to utilise friendships and local support services, care provision was relatively low and some were forced to either return to the UK or turn to the rapidly expanding private care sector (Da Roit, 2007). However, private care is expensive and a significant drain on financial capital. A lack of care can therefore lead to increased vulnerability.

British charities, including Age Concern España, were found to play an important role in supporting those with care needs. The help they offer includes providing transportation to and from medical appointments, translating in hospitals and organising (but not financing) carers. All interview respondents were Age Concern España service users, and most felt that they would have been unable to cope with their health and care problems without the support of Age Concern volunteers. For most, this led to an improved quality of life, thereby highlighting how British charities may play a key role in supporting vulnerable, older British people in Spain with their health and care needs. Help and support from British charities may even, in some cases, replace that provided by statutory services.

### **8.2.2 Financial Resources**

Many older Northern European people who retire to Southern Europe are in a relatively privileged financial position and are not reliant on state benefits at the time of moving (King *et al.*, 2000; Ackers and Dwyer, 2002). However, there are increasing numbers of working class, low income households moving to destinations in Spain (King *et al.*, 2000). Some vulnerable, older British people who are reliant on state benefits as their only source of income were profiled in this thesis (see Chapter Seven). These people often moved to Spain to increase the purchasing power of their pension through lower living costs. The financial situation of older British people in Spain is a largely neglected area both in research and policy, so this thesis goes some way to filling this gap in the literature.

Financial difficulties were frequently cited by respondents, with two-thirds (65%) of interviewed households experiencing financial difficulties. A wide range of financial difficulties were mentioned, often as a result of changing individual circumstances or wider economic situations. Most respondents had seen a considerable rise in living costs in recent years, which had negatively impacted on their disposable income and purchasing power. Equally, exchange rate fluctuations can also affect income. Since the data for this thesis was collected, there has been a sharp decline in the value of the Pound against the Euro. There are growing reports of older British migrants encountering severe financial difficulties (Davys, 2009; Britishexpats, 2008;

Toorney, 2009) and Age Concern have seen a considerable increase in the number of requests for financial support (Age Concern, 2008), with some returning to the UK as a result. Therefore, shifting economic conditions can dramatically reduce income and negate all economic advantages of moving abroad, leading to extreme vulnerability. Further research on the financial situation of older British people in Spain in the current economic climate is recommended.

Unexpected financial need can arise from a decline in health and the resulting need for care. However, Spain has a less generous welfare system than the UK and most UK benefits are not exportable to Spain. Some participants were unaware of this and as suggested in previous research (Age Concern, 2007), there is a general expectation among older British people that the same level of financial support is available in Spain as it is in the UK. This indicates a vast discrepancy between the expectation and reality of financial support. Whilst this can be attributed to poor preparation and research, it may also suggest a lack of information and financial support for British people in Spain. The British government appears to be recognising this, having introduced a new support and liaison team funded by the DWP based at the British Consulates in Alicante and Malaga (FCO, 2007). However, in the current financial climate, further support may be required.

One source of financial support for older British people in Spain comes from UK based charities, including Age Concern España. Whilst they only offer limited financial help, they are able to signpost people to other sources of support, including the benevolent funds of HM Forces and occupational charities, which can provide grants or ongoing payments for those in financial need. Six interview participants had received money from HM benevolent funds, which they found had substantially improved their quality of life. However, support from benevolent funds is likely to decline, as fewer people have served in HM Forces in the post-war period. Whilst there are a number of occupational charities that offer support to older British people, few participants had access to these. Another option for those experiencing financial difficulties is to return to the UK to access welfare benefits and some participants were undertaking a return for this reason. However, for many this was a move of necessity rather than choice, out of fear of becoming destitute in Spain (see Section 8.4).



### **8.2.3 Social Resources**

Good social relationships with family and friends, as well as the wider community have been linked to successful ageing and can reduce vulnerability and isolation (Bowling, 1991). Social networks can also be utilised to provide social capital in the form of instrumental, emotional and informational support. A lack of social support can result in social and emotional isolation, which has been recognised as a significant challenge facing some older British people in Spain (Mullen, 1993; Huber and O'Reilly, 2004). Whilst many older people encounter isolation (van Baarsen *et al.*, 2001), it may be more acute for older migrants as their social networks may be subject to significant change when they move. Established networks comprising family and friends are often left behind in the UK and new ties must be established (O'Reilly, 2000a; Wenger, 1997). This thesis has shown how the social networks of older British people in Spain can change significantly following migration; however, for some this results in larger and more diverse networks, whilst for others networks are diminished. What was also particularly evident was the extent to which social networks can decline as an individual becomes older, frailer and more vulnerable. The social networks of interview participants were organised using the Grid and Group theoretical frame and were presented in Chapter Four, the conclusions from which will now be discussed.

## **8.3 Social Networks and Transnational Support**

### **8.3.1 The Grid and Group Typology**

The Grid and Group framework has been used in this thesis to examine the ways in which vulnerable, older British people in Spain respond to challenges or crises by drawing upon their social networks for support. It has looked at the characteristics of individual respondents and their social networks (formal and informal), as well as the wider social, cultural and political environments within which individuals are located. This includes the impact of cultural and language differences, as well as local, national and international policy. The analysis has led to the emergence of four distinct types of social network organisation; Isolate, Enclave,

Individualist and Hierarchy. As discussed above, all respondents were considered to be vulnerable due to the challenges they faced; however, some were able to cope more effectively with these challenges by drawing on their social networks for emotional, tangible and/or informational support. The nature and extent of vulnerability therefore varied according to the type of social network organisation within which that individual was located.

This framework presented four ideal types and therefore some people did not fit neatly into one category. Some respondents were found to live under hybrid forms (Hardill *et al.*, 2007), possessing characteristics from two or more groups. An example of this is Shirley, who was classed as an Individualist through her husband, as he possessed strong Individualist tendencies by which he and Shirley lived their lives. However, Shirley was very dependent on her husband and did not have the strong ties to Spain that other Individualists had. She was therefore considered to be a hybrid type with characteristics of both an Individualist and an Isolate. The framework also highlighted some movement between types especially as an individual ages and their circumstances change. For example, before her husband died, Elsa had a good social life in Spain, was well supported within the British community, and so was an Enclave. However, as a widow, she does not socialise and remains confined to her home. She has become dependent on her daughter, one neighbour and an Age Concern volunteer and is now considered to be an Isolate. Her lack of support from the Spanish community appears to have compounded her isolation. This therefore captures the complexity of life during old age and the negative impact of a change in circumstances, especially bereavement. Ageing tends to bring with it greater challenges and a reduction in the social, physical and financial resources needed to cope with them successfully, thereby resulting in increased vulnerability. This thesis has shown how social support is especially important in reducing old age vulnerabilities.

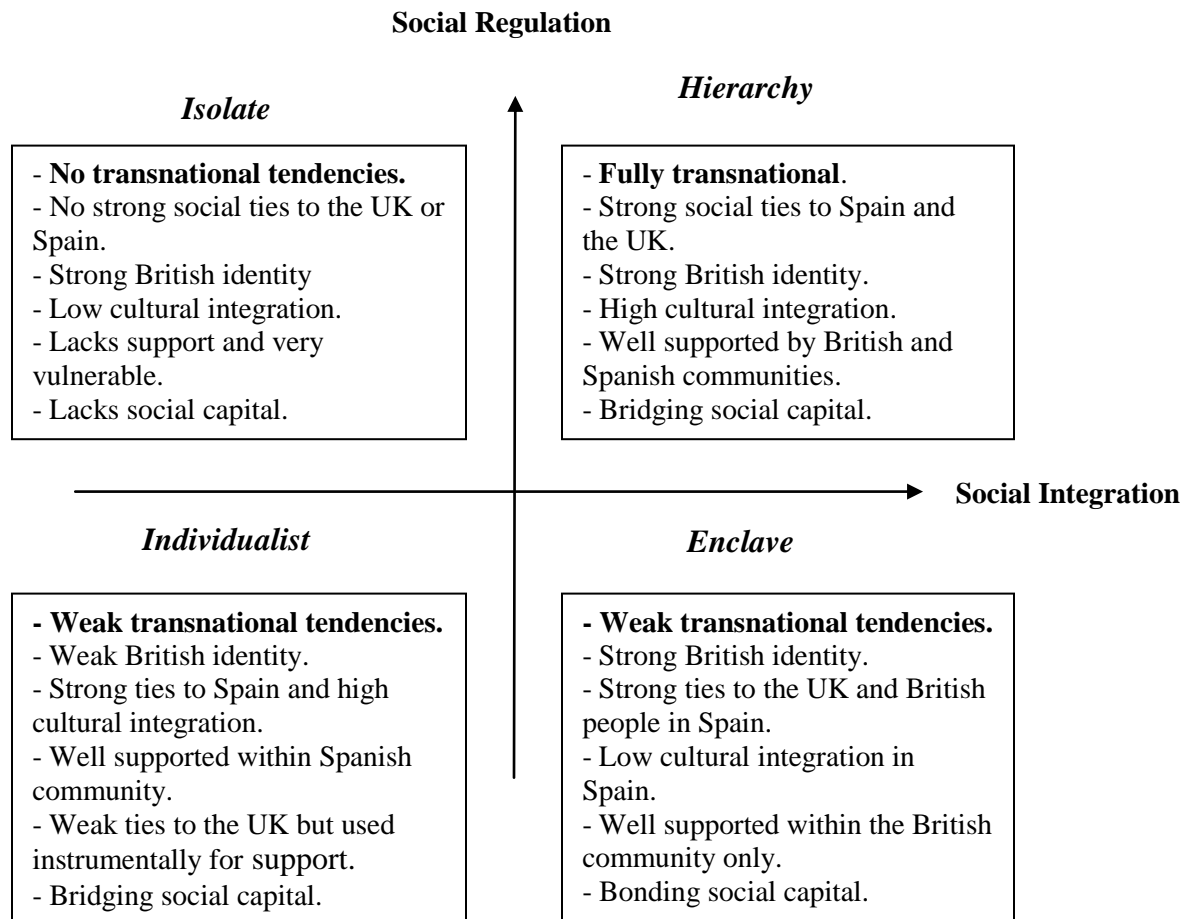
### ***8.3.2 Transnational Support and Social Capital***

Through the use of the Grid and Group framework, this thesis has examined the social and support networks of vulnerable, older British people in Spain. This includes not only the type of network, but also its location and therefore the extent to which individuals maintain transnational

networks. To be transnational is when “lived experiences transcend the boundaries of nation-states” (Bailey 2001: 414) and when people “develop and maintain multiple relationships – familial, economic, social, organizational, religious and political – that span those borders” (Basch *et al.*, 1994:7, cited in Bailey 2001:414). The academic literature on transnationalism is dominated by labour migration, whilst the experiences of retired older people have been largely ignored (except Gustafson, 2001). This thesis has focused on vulnerable, older British people in Spain, and where their identities, networks and lifestyles are embedded and more specifically, from where they seek support. It is therefore looking at transnationalism within a new context and in doing so it has identified the diverse, flexible and complex forms that retirement migration can take.

The findings from this study suggest that vulnerable, older British people in Spain are transnational to some extent; however, the degree and nature of transnationalism contrasts significantly from person to person. This ranges from those who are truly transnational as they are well-integrated into and supported by both the Spanish and British communities; to those who have limited or no ties in the UK and Spain and therefore very little support. Therefore, as has been previously suggested by some authors, some older British migrants maintain strong social networks in the UK, whilst for others links are weak or have dissipated (Huber and O'Reilly, 2004; Hardill *et al.*, 2005). Through the application of the Grid and Group framework, four distinct types of transnational behaviour have been identified based around how social networks are utilised for support. These are shown in *Fig. 8.1* and are discussed below in order from the most transnational (Hierarchy), to the least transnational (Isolate).

**Fig. 8.1 – Four Types of Transnationalism among Vulnerable, Older British People in Spain**



First are the Hierarchy types who are truly transnational, as they maintain strong links to both Spain and the UK, are strongly embedded in the networks and cultures of each country, and feel a sense of belonging in both countries. They are able to maintain a collective British identity, yet lead a full and integrated life in Spain (with both Spanish and British communities). This is evidence of strong bridging social capital, which encompasses people across diverse social cleavages (Putnam, 2000). For Hierarchy types, social capital was used to access information and support from both the UK and Spain, including from Age Concern, UK charity benevolent funds and Spanish nursing homes. They are therefore emotionally and financially dependent on both the UK and Spain and this diversity of support allows them to cope effectively with the challenges they face, thereby reducing their vulnerability.

Second, the Individualists are those who are well integrated into the Spanish community and maintain only weak ties to the UK. They tend to dismiss the British community in Spain in favour of the Spanish, so their lifestyles and emotional attachments are located more firmly in Spain. As such, they were able to generate support from the Spanish community, including from their local Spanish Town Halls. However, they were also able to effectively utilise their British nationality to obtain financial support from British based organisations and charities, indicating some transnational tendencies. This shows evidence of strong bridging social capital (Putnam, 2000), as their diverse social networks were used instrumentally to generate support from the Spanish and British communities. This diversity of ties allows them to cope effectively with the challenges they face. Their characteristics are very similar to the Hierarchy types; however, the key difference is that they are only financially, rather than emotionally, dependent on the UK.

Third, the Enclaves are those who have developed strong social networks in Spain but only within the British community. They have maintained a British identity and lifestyle despite living in Spain and are culturally, emotionally and financially dependent on the UK. From the outside, it would appear that they are still living in the UK, as they have not embraced any elements of Spain (except the weather!). Their strong collective identities liken them to a Diaspora, as the homeland makes significant claims on their loyalty and emotions (Cohen, 1997). Whilst they possess social capital which they can use to generate information and support, this is bonding social capital as it is contained within a homogenous group i.e. only with other British people. Bonding social capital can serve to exclude, as it can close off contacts with the wider group (Patulny and Svendsen, 2007), which for the Enclaves is the Spanish community. The Enclaves were segregated from the local Spanish community and did not directly access Spanish support services. As a result, some Enclaves became Isolates as they aged due to a lack of local support, possibly resulting in a need to return to the UK. They are therefore at risk of vulnerability in old age.

Finally, the Isolates are those who have limited social networks in either the UK or Spain, so cannot be considered to be transnational. They possess similar characteristics to the Enclaves, as they have maintained a British identity and lifestyle and reject the Spanish community and culture. They remain culturally, emotionally and financially dependent on the UK. However, in

contrast to the Enclaves, they have very little or no social capital due to their weak networks, and as such are largely unsupported. They demand the greatest amount of support, yet are unable to obtain it making them an extremely vulnerable group. This has led to most Isolates needing to return to the UK to access support.

### ***8.3.3 Obtaining ‘Virtual’ Transnational Support***

Maintaining transnational relationships has become easier in recent years with the advent of modern ICTs, such as email communication. ICTs can therefore be used to generate support from people living at a distance, which for older British people in Spain is most likely to be family (and possibly friends) living in the UK. Research shows that some British migrants do use ICTs to maintain transnational relationships (O’Reilly, 2007); however, the use of email and other forms of electronic communication among respondents in this study was low, especially among the older interview respondents. The limited use of email among the older British community in Spain was also indicated by only 3% of survey enquiries to Age Concern España being via email. Instead, there was a strong reliance on the telephone as a means of communication to stay in touch with friends and family in the UK.

Nonetheless, some interview participants expressed their desire to use the internet and a small number already used email. Furthermore, since opening their Information Line in 2006, Age Concern España are investing in their email and internet services in an effort to get more older British people online. This supports research (e.g. Selwyn *et al.*, 2003) suggesting that a greater number of older people are using ICTs. As such, the maintenance of virtual relationships by older British migrants, whilst not extensive at the current time, is predicted to expand in coming years as younger, more computer literate adults reach retirement age. This should allow the easier maintenance of a transnational lifestyle and greater opportunities to access information and support.

## 8.4 Returning to the UK for Support

This section concludes the theoretical implications of the study by briefly discussing the experiences of participants who return to the UK, which for most is a last resort and tends to occur when health, financial and social resources are depleted. Previous research has highlighted the difficulties of returning to the UK to access statutory support (Ackers and Dwyer, 2002; Hardill *et al.*, 2005). The most commonly cited reason for older British migrants returning to the UK is to access health and social care services, including residential care (Dwyer, 2000; Warnes *et al.*, 1999). Some interview participants did return for this reason, especially to access nursing homes. However, most participants were also returning to access UK welfare benefits, including Pension Credit and Housing Support. In addition, returning to be near friends and family, especially following bereavement, is recognised as a reason for returning (Ackers, 2004) and those who are not integrated in Spain are the most likely to return to their country of origin (O'Reilly, 2004). This claim is strongly supported here as many of the non-integrated Isolates and Enclaves were organising or considering a return to the UK due to a lack of support in Spain. This is in dramatic contrast to the largely integrated Hierarchy and Individualist types whose life in Spain was usually one of permanence.

The number of older British people who live in Spain and later return to the UK appears to be increasing; with Age Concern España receiving approximately eight enquires a week on repatriation (based on data from the survey of enquiries). This research has highlighted the practical difficulties that older people encounter when returning to the UK, with the HRT in particular hindering access to financial support. Furthermore, the need to present to Social Services in person is also restricting access to social care and housing. Some participants spoke of the emotional distress caused as a result of these restrictions, as well as the financial costs incurred. There are sources of support for those returning to the UK, including Age Concern España and Heathrow Travel Care; however, despite their best efforts to ensure vulnerable British people can access support upon their return, residency rules and care restrictions make this difficult. As Anaman (2007a) has previously suggested, most older people undertaking a return move to the UK are elderly, frail and vulnerable as a result of poor health and/or severe financial problems. Yet such people are prevented from claiming essential financial and care

assistance despite their high level of need. This thesis argues that elderly, vulnerable British nationals who are re-establishing their former ties with the UK, should be entitled to immediate support (financial and care) upon their return. Such issues have been raised for working migrants (e.g. ECJ case of Swaddling); however, the same reasoning should be extended to retired migrants (Ackers and Dwyer, 2002).

## **8.5 Practical Implications of the Research**

The data for this study was collected through Age Concern España and used to promote the needs of vulnerable, older British people in Spain. It has been used to produce two reports; a policy report for Age Concern England, and a service development report for Age Concern España. The first report provides detailed policy recommendations, particularly on the health, care and welfare entitlements of older British people in Spain. It has been disseminated to policy makers in the UK and Spain. The second report details the findings from the survey of enquiries to Age Concern España and includes recommendations for good practice to be utilised by Age Concern España (and other voluntary organisations in Spain). The key findings from each of these reports are presented below.

### ***8.5.1 Policy Recommendations***

The following are a series of policy recommendations developed in partnership with Age Concern, to be implemented at national and international levels by the British and Spanish governments.

- Provide accessible information and guidance in three key areas. First, British policy regarding returning to the UK, especially on the HRT. Second, the exportability of benefits and healthcare. Third, the availability of social care in Spain. Information should be widely



available in English, in a clear and simple format and distributed through UK based charities or governmental organisations.

- Older British people in Spain would benefit from affordable transport to medical appointments. This could be via organisations such as Age Concern España. Information should also be more widely available in English on Spanish hospital transport services, including the ambulance service.
- Insufficient care provision for frail, older British people in Spain results in some returning to the UK to access care services. Providing care services for older British people in Spain would enable them to remain in Spain and reduce costly returns to the UK. Care services in Spain could include low-cost British owned nursing/residential homes and sheltered accommodation with English speaking staff. Alternatively, making Direct Payments exportable would enable older British migrants to purchase care in Spain.
- Older British migrants should be encouraged to learn Spanish through affordable lessons, possibly via organisations such as Age Concern España.
- Further information, guidance and support should be provided to prepare people for exchange rate fluctuations, especially for those living on the British state pension.
- People who have spent the majority of their lives in the UK and are resuming a previous residence should be able to pass the HRT immediately upon arrival in the UK.

### ***8.5.2 Recommendations for Good Practice***

The following are a series of recommendations designed to improve the services of Age Concern España (and other voluntary and community organisations) at a local level in Spain.

- The changing demographic profile of older British nationals in Spain has resulted in greater care needs among the British community. Need is greatest among those who are widowed or living alone and do not have family and friends nearby to help. Many have to pay for private care services and there is therefore an increasing need for care provision in Spain, either provided by the local authorities or charities.
- A large majority of older British people in Spain speak very little or no Spanish. Whilst Age Concern España do provide translating services, these could be expanded in response to this growing need, especially during medical appointments or when dealing with local bureaucracy. This could be provided either by Age Concern España (even if there is a small charge for such services) or through other agencies.
- The survey of enquiries suggests that older men only appear to be contacting Age Concern España when they have a particular need, such as for transport, translations or repatriation. Therefore, new and innovative ways of engaging with older men could be developed, as well as a consideration about their specific needs.
- Age Concern España relies on the unpaid work of volunteers, most of whom use their own knowledge to respond to enquiries. It is therefore vital that the skills and knowledge of all volunteers are regularly updated.
- The physical base of the Age Concern España centre has been shown to be very positive in terms of social support for both clients and volunteers, and should be encouraged where possible.
- Email is a growing means of contacting support services like Age Concern España. This should be encouraged as email is a key way to alleviate social isolation and loneliness (Findlay, 2003). Age Concern España should use it as a way to reach older isolated people.

## 8.6 Recommendations for Further Research

There are a number of areas where further research will be useful. Recommendations for future research include the following;

1. The research for this thesis was conducted during a time of economic stability. Research needs to be undertaken on the financial impact of the 'Credit Crunch' on older British migrants in Spain. Particular notice needs to be taken of those on a fixed income and reliant on the British state pension as their only source of income. It is anticipated that financial challenges among these individuals has increased significantly in the past two years.
2. Whilst this study has included participants living in Spain but who are in the process of returning to the UK, research needs to be undertaken on the experiences of older migrants during and after their return to the UK. This remains an under researched area and as such, the experiences of returning older migrants are largely neglected from UK policy.
3. This and previous studies have identified a status differentiation between groups of retired migrants based on their age and economic status e.g. early retirees have fewer rights in Spain than those who have worked there. This has implications for future studies on citizenship and the transferability of rights within the EU.
4. This thesis has illustrated the value of a collaborative study which engages in the co-production of knowledge and knowledge transfer. It is hoped that this approach continues to be funded and embraced by researchers.

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# Appendices

## **Appendix 1 – The Proforma**

### **Enquiry to Age Concern**

Date: \_\_\_\_\_ Time: \_\_\_\_\_ Name of Volunteer: \_\_\_\_\_

**Type of enquiry:** ☐Phone ☐Face to Face ☐Email ☐Letter ☐Other \_\_\_\_\_

**Is this enquiry for...?** ☐You ☐Spouse/Partner ☐Parent ☐Friend ☐Other

*Nature of the enquiry (please tick all that apply)*

☐ Medical/Health ☐ Care ☐ Financial ☐ Bureaucracy ☐ Donation ☐ Local amenities ☐ Other

Please provide further information

*Action taken on the enquiry (please tick all that apply)*

- ☐ Information provided by Fact Sheets (Please state fact sheet) \_\_\_\_\_  
☐ Information provided by knowledge of volunteers  
☐ Referred to local LIFELINE  
☐ Referred elsewhere (Please state) \_\_\_\_\_  
☐ Other (Please state) \_\_\_\_\_

Please give details for the person for whom the enquiry relates

Nationality: ☐British ☐Spanish ☐German ☐Swedish ☐Other \_\_\_\_\_

Gender: ☐Male ☐Female

Age (please state) \_\_\_\_\_

Area of Residence (please state) \_\_\_\_\_

Marital status: ☐Married ☐Living with Partner ☐Separated ☐Divorced ☐Widowed ☐Single

Number of years lived in Spain (please state) \_\_\_\_\_

Number of months per year spent in Spain (please state) \_\_\_\_\_

Have you or your spouse ever served in HM Forces? ☐ Yes, myself ☐ Yes, spouse ☐ No

What was your main occupation? \_\_\_\_\_

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Please Detach if Personal Details are Recorded

**We would like to interview a number of people who have been in contact with Age Concern. Would you like to take part in an interview with our research student Kelly who will ask about your experiences of living in Spain? You will remain completely anonymous.**

☐ Yes ☐ No

Name \_\_\_\_\_ Address \_\_\_\_\_

Phone Number \_\_\_\_\_ Email \_\_\_\_\_



## **Appendix 2 – The Interview Guide**

### **Part 1 - Moving to Spain**

Why did you decide to move to Spain?

What were your circumstances before you moved to Spain e.g. work, health?

### **Part 2 - Life in Spain**

Can you briefly explain what your average day in Spain involves?

Has life in Spain changed since you first arrived? If so, how?

If not a permanent resident –

How do you manage your life between Spain and the UK? Where do you prefer to be and why?

### **Part 3 - Social Networks**

What activities do you regularly undertake in Spain e.g. social clubs, work.

Tell me about the people who are important to you now in Spain /UK /elsewhere e.g. friends/family/neighbours?

Which people are most important? Why? Describe your relationship with them e.g. how often do you see them? In what circumstances do you see them?

Have your relationships with your friends and family changed since you moved to Spain? If so, how?

Do you feel part of a British community in Spain?

Do you feel part of the Spanish community?

If a voluntary or formal organisation has been used, ask further about why they were used, what they did to help?

#### Part 4 - Problems/Challenges Encountered

Ask for more information on any specifically mentioned problems on the questionnaire;

Expand on;

What happened?

Who they turned to for support/help – formal and informal?

What was the outcome?

Could have anything have been done to help you resolve the problem?

Do you think that anything could have been done to prevent the problem/prevent the problem happening to someone else? E.g. by British or Spanish government

Ask about each of the following areas if no problems are mentioned;

Health/medical

Social care

Finance

Bereavement

Bureaucracy

Language

Are there any other significant issues or problems affecting your quality of life in Spain?

#### Part 5 - Information

Have you had any problems accessing adequate information whilst in Spain e.g. on bureaucracy, including residency, health/social care, benefits, life in Spain, support available for British people?

#### Part 6 - The Future

Ask more about future plans

Ask where they consider 'home' to be.

#### Part 7 - Further Information

Are there any further issues that you would like to discuss regarding your life in Spain that you think would be relevant?

### **Appendix 3 – Participant Information Sheet/Interview Consent Form**

#### ***Research on Older British People Living in Spain***

#### ***Information Sheet and Consent Form***

I am currently conducting some research on the experiences of British people over the age of 50 living in Spain. The research is particularly looking at the challenges older people living in Spain face and the methods used to cope when these arise, such as friendships, family and the use of voluntary and other organisations. I would like to invite you to be part of this research by taking part in an in-depth interview. The interview will be conducted face-to-face in a place of your choosing (this may be your home or the Age Concern Centre). You may choose to be interviewed on your own or you may have someone else present, such as a friend or partner/spouse.

The interview will be conducted by a PhD student from the Nottingham Trent University. The questions will ask about yourself and your life in Spain, your friends and family and about any problems or challenges you have faced since living in Spain. The interview will last approximately one hour and subject to your consent will be tape-recorded. Please feel free not to answer any questions you are uncomfortable with. All the information collected will be treated confidentially and you will not be identified in any form of data dissemination. Therefore, I would be most grateful if you could answer all questions as openly as possible.

The information collected will be analysed anonymously and presented to a range of outlets including *Age Concern*, academics and policy makers. It will also be used to complete a PhD thesis. This study is funded by the *Economic and Social Research Council* and *Age Concern*.

I am very grateful for your important contribution to this research. Thank you for your time.

***Kelly Hall***

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I agree to take part in an interview for the above research

Signed: \_\_\_\_\_

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

## **Appendix 4 – An Example Pen Portrait**

### **PEN PORTRAITS - IDA**

**Name** Torrevieja Female 4 Ida

**Age** 79

**Household Structure** Lives alone in a terraced house on an urbanisation very close to Torrevieja centre. Was divorced before she moved to Spain.

**Years in Spain** 16

**The Interview** – Took place at her home with only the interviewer present. Interview lasted approx 1 hour 30. Was very informal. She started talking about her problems as soon as I walked through the door as I had already met with her a number of times at the Age Concern centre. Half way through the interview she showed me around her house so the tape recorder was stopped.

### **Reason for moving to Spain**

Health reasons – for a better climate. Her daughter was going to live in America and she was going to go with her but didn't want to in the end because of the crime (she thinks this is ironic as she has been the victim of a number of crimes in Spain). At an exhibition she picked up some leaflets about Spain and came out on a 4 day inspection with her daughter. Then stayed in work friends flat in Torrevieja for a while before moving. Her daughter then lived with her for a while after she met a Spanish man and then bought her own place nearby.

### **Hierarchy**

Is becoming more isolate due to old age and poor health. Used to be more hierarchy and have a very good social life. Quite fed up with old age - "life used to be great fun."

### **Social Network/Support**

#### ***Family***

Has 2 daughters. One lives in Spain approx 10 miles away who she sees very often and speaks to every day. Doesn't live in the same place, as her as it's in the mountains, is too hot in the summer and cold in the winter and has no amenities.

Daughter used to live with a Spanish man and they are still friends so he sometimes helps her if she is in trouble "Anyway, my daughter she used to live with a Spaniard for 9 years, they are still friend, so she told him, he phoned me up and said I am going to take you to a doctor and get this sorted out."

Her other daughter lives in the UK and she is also very close to her. Both daughters stay with her often. She is quite reliant on her daughters especially during times of ill health – the daughter in Spain is first person she will contact in an emergency and will provide care – "My daughter had to feed me with a spoon".

Daughters also helping her financially to return to the UK.

Would like to live near her daughter but "She hasn't got a shop, a bar, a bus, a doctor, nothing. That's how she likes it. She drives but I don't so it's no good for me."

Has an elderly sister in the UK who is too old to be able to visit. “My sister is 87 and her husband is and she is not well enough to come out here, she never has been. You want your family.”

Still speaks to ex-husband in the UK occasionally.

“I am alright on my own for a little while but I need to talk. My [daughter] phones me every day and [other daughter] phones me once a week and I phone her and I do write a lot of letters. I write to my sister regularly, thousands of words I have written over 16 years but she likes to know all the gossip and what I do and everything.”

### ***Friends***

Has 3 friends in the UK – 2 of them are friends she had in Spain and have returned.

“I have been very lucky out here with friends”

Has many friends in Spain however some have died or gone back to the UK – so her social network in Spain is rapidly declining. She also now has limited mobility so can't go out very often.

“A lot have died and I wouldn't say I have got a lot now. I did have. A friend of mine has just gone back. She hasn't sold her flat, a little one, she has bought one in Bournemouth another one has bought one in Sussex, another one has bought one in Somerset. That was 3 of my friends.”

Has a friend she used to work with whose apartment she stayed in when looking at property – this friend only visits Spain occasionally now due to poor health.

Friend takes her shopping once a week and others take her to hospital (which she does often pay them for) and care for her is she is not well - “[friend] came, she would do little things for me and for 3 days, I couldn't wash, I couldn't...I was in such a terrible state.”

The friend who takes her shopping has got a key for her house.

Wants more community support that she feels she will be get in England (see future).

Has had friends from all different nationalities including Spanish “I had Norwegians, Swedes, Danish, Finish, Belgian, I can't remember now, all nationalities.”

Her health problems have made it less easier to socialise – “I am a very friendly person, a very honest person and I do make friends easily but when you are ill you can't be bothered, when you are in a lot of pain.”

### ***Formal Support***

Gets picked up and taken to the Age Concern centre most weeks – is friends with the people who go on the same day as her and sometimes sees them away from the centre. Thinks that she doesn't get enough time at the centre each week as by the time they get there after picking people up, it is almost time to leave.

Has been to the Age Concern luncheon club but stopped because she found too many people smoked, and goes on the Age Concern outings which she thinks are very good “The day out and lunch was about 18 euros. They picked me up from here and brought me back here. I think they do a great job.”

Age Concern volunteers brought back some medical equipment from England for her “Then this Pam, she was going to England and she said do you want anything and I said do you mind getting me some of those heat pads, they are ever so good, so she brought me some back. I gave her the money and she wasn't going to take it but I insist on paying my way” and take her out to concerts etc.

Has looked into getting carers but is too expensive.

### ***Social Clubs/Activities***

"I run a gardening club I have done that for 6 years... We go out every other week socially, and it's so lovely but I can't walk very far without pain. They want to get me a wheelchair and I said no way."

Used to run another social club:-

"I did solo's international for 6 and a half years, just to meet people, not a man. Meet people and have a social life."

Wanted to start a tea club but was worried about " people taking advantage"

Goes out with friends for lunch.

Her health problems are getting her down and feels like she is "ready to go"

"Although I am old anyway, I have had my time and I shouldn't feel like this, but inside I am young."

Also does not like using wheelchairs:- "I have to have a wheelchair and I am embarrassed by it, it's awfully embarrassing when your faculties go. Its kind of, I don't know, its hard old age. It is hard."

Used to go out a lot and now stays in and watches the tv and reads, she says "I never thought I would get like that"

### ***Links with UK***

Wants to return to the UK and is trying to sell her house. Has recently moved all her money back into a UK bank account.

Has a daughter and sister in the UK

3 friends in the UK.

Used to return to the UK regularly, she went last year for 3 weeks and stayed with her daughter. Is now not going to return to the UK until she sells.

### ***Integration***

Speaks a "fair amount of Spanish". A Spanish friend taught her a lot of Spanish but she moved away after being mugged.

Can just about manage to speak to the doctors in Spanish – she has to write it down.

"I speak a fair amount of Spanish, I can usually get by, but you know it is very frightening especially when your body starts playing you up and you don't know what's what."

### ***Health/Health Care***

Has many health problems and experiences a lot of pain. Has to go to the doctors and hospital regularly. Says the doctors surgeries and hospitals can be "unorganised chaos" – says she is sent back and forth between different places. Doesn't understand the system.

Hurt her back at xmas (6 months before) which left her almost immobile. Was given some injections to do at home – either her friend or daughter did this for her. Her daughter and friend looked after her e.g. had to feed her at one point when she couldn't move – "I was really extremely ill and [friend] came, she would do little things for me and for 3 days, I couldn't wash, I couldn't...I was in such a terrible state."

When she was in the UK she fell off a ladder and hurt her leg and she is still having problems with her leg. She has also had blood clots in her leg.

Has severe headaches, has high blood pressure – which both cause her problems.

Also has glaucoma and cataracts

### **Social Care**

No social care available - she is lucky to have her daughter and friend who help.

“when you come out of hospital, it doesn’t matter how ill you are, you are on your own. At least in this area. I believe in some small areas, there is a nurse that calls. But what happens to you if you can't walk, you see. I believe if I couldn’t walk I could probably get in a Spanish nursing home because, but only for a short time. It’s a question of money.”

Has looked into getting care at home but thinks it is too expensive.

### **Financial**

Has found living costs have increased a lot.

Is having problems selling her house – it has been on the market for a number of years and has had little interest.

Is worried about what she will be able to afford in the UK. Her daughters are going to help her buy somewhere “The village I want to be in which has had the award for old people has got everything. It is about 200,000 for a 1 bedroom. I want a 2 because [daughter] is going to help me. She has got a little old flat, ex-council, 1 bedroom in England. When I sell this, she is going to sell that to give me the money to put towards the 100,000 to help me buy a place and then my 2 daughters want to try and have a small mortgage to pay the rest for me.”

### **Other Problems**

Transport – has to pay someone with a car to take her to her appointments.

Has been robbed a number of times “I didn’t know I was going to be robbed left right and centre out here.” Is now very scared and doesn’t like going out on her own – “Alright there is crime here, I never go out at night unless someone takes me, so I am kind of like in a prison.”

Finds it too hot in the summer months.

### **Information**

#### **Future and Home**

Wants to return to the UK where her “roots are” and for health reasons “because if you speak the same language you can say so much more”. Wants to go back to a small village where people are more likely to help if she becomes ill. Is worried about what would happen to her in Spain if she became very ill:-

“I just think that in a little village in England where the doctor is nice and you can go in the shop and get your paper and you will be known and if you are not seen about they might look for you

or something. If you are on the floor you see. But here, the director of the community is across there and I don't think they even knew I was here."

### **Comments and Policy**

Quote to sum up interview - "I think Spain is wonderful if you have got a spirit of adventure, if you learn the language or get by or are fit. When you are old and ailing it's not so good."

Wants to maintain dignity "I can't walk up the aeroplane steps anymore, I have to have a wheelchair and I am embarrassed by it, it's awfully embarrassing when your faculties go. Its kind of, I don't know, its hard old age. It is hard."

Wishes she has moved to Spain at a younger age – "I'd like to have my time over again. I would have come out here when I was 50 I think."